Solutions (Yorkshire) Limited

Harewood Court Nursing Home

Inspection report

89 Harehills Lane
Chapel Allerton
Leeds
LS7 4HA
Tel: 0113 226 9380

Date of inspection visit: 22 and 28 July 2014
Date of publication: 12/12/2014

Ratings

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

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2012 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 2012, and to pilot a new process being introduced by CQC which looks at the overall quality of the service.

Harewood Court provides nursing and personal care for up to 40 people. The service is divided into two units with the second floor accommodating people who were living with dementia. At the time of our visit there were 34 people living at Harewood Court.

This inspection was unannounced. At our last inspection in January 2014 we had identified breaches of regulations related to care and welfare, the management of medicines and staffing levels. Following this visit the

Summary of findings

provider sent us an action plan telling us the improvements they were going to make. During this inspection we looked to see if these improvements had been made. We found improvements still needed to be made in each of the areas where we had previously raised our concerns.

The Registered Manager, who was also a director of the provider group who own Harewood Court, had been in post since 2012. 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.

People were not always protected against the risks associated with the unsafe use and management of medicines, particularly following admission or readmission to the service. Although a new medicines system had been introduced, the service's policy and procedure had not been updated to provide staff with the necessary guidance.

People who used the service, their relatives and staff all told us there were not enough staff at the service. We saw this had led to some routines that focussed on tasks rather than the person when supporting people who required additional support.

Although we found a lack of information related to the requirements of the Mental Capacity Act 2005, referrals had been made to the local authority where people required their support to be authorised as it restricted their freedom. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

We had raised concerns at our first visit regarding aspects of cleanliness and infection control and fire evacuation procedures; however, these had been addressed for our return visit.

Staff received training and supervision to assist them in undertaking their role. We raised concerns about the lack of support and guidance provided to volunteers.

People were supported to maintain a balanced diet. Where people were at risk of malnutrition appropriate risk assessments were in place and people were supported to maintain a good nutritional intake. Catering staff worked with care staff to identify those people requiring fortified diets.

People were supported to access appropriate health professionals where they experienced a change in their health and well-being.

Care was not always delivered in a way that was responsive to people's individual needs. Some practice was task oriented and lacked compassion. Some care records did not reflect people's current needs and had not been updated.

People who had not had reason to complain told us they were aware of how to make a complaint if necessary. However, two people who had cause to complain had poor responses to the concerns they raised. The wording of the provider's whistleblowing policy and response to complaints actively discouraged people from raising concerns.

People had access to in-house activities that were run by staff at the service, external activity organisers and volunteers.

The management arrangements made it difficult to be clear about individual's roles and responsibilities. The leadership team did not always act in a way that set a positive example to more junior staff.

Quality monitoring processes did not always identify shortfalls in quality. Where shortfalls had been identified these had not always been addressed.

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.

Where people's liberty was restricted in order to help them stay safe appropriate referrals had been made to the local authority. We therefore found the service to be meeting requirements related to the Deprivation of Liberty Safeguards.

There were not enough staff at the service. This had led to task oriented practice and un-witnessed/unexplained injuries.

Medicines were not managed safely. Particular risks were identified around admission to the service.

Where concerns had been identified regarding fire evacuation and cleanliness these had been addressed for the second visit of our inspection.

Is the service effective?

Requires Improvement

The service was not always effective.

Although staff received supervision and training the service did not provide support to volunteers. This impacted on the quality of support people received.

People were supported to maintain a balanced diet. Where people were at risk of malnutrition their dietary intake was monitored and referrals made to dietetic services as required.

People were supported to access health care professionals as required. Documentation to aid communication and consistency of care when people required admission to hospital had not been completed.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed staff provide support to people without any reassurance or explanation of what they were doing.

Although we observed some examples of good care practice by some staff we found other staff to be abrupt and lacking compassion. Some practices reflected a task oriented approach to care. This meant people's care was not always provided in a way that reflected their individual needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

People's care did not always reflect their assessed needs. Where people's needs had changed this had not always been recorded to ensure all staff were aware of changes in need.

People had access to in-house activities. The service employed dedicated activity staff and external agencies to provide activities and entertainment to people who used the service.

Relatives of people who used the service told us they were aware of how to make a complaint or provide feedback. When people had cause to complain they did not always receive a response that promoted an open culture or encourage them to raise concerns in the future.

Is the service well-led?

Inadequate

The service was not well-led. The management arrangements meant that some people who used the service and their relatives were not always clear about who to contact.

Relatives told us communication between staff was poor. We saw examples of lead staff setting poor examples to other staff within the service. This was defended by senior management.

The provider's whistleblowing policy and response to complaints actively discouraged people from raising concerns.

Quality monitoring processes were not effective in identifying and addressing areas where improvement was required.

Harewood Court Nursing Home

Detailed findings

Background to this inspection

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.

This inspection team consisted of two adult social care inspectors, a pharmacy inspector, a specialist professional advisor in dementia care 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.

Before the inspection the provider completed 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. Before our inspection, we reviewed the information included in the PIR along with information we held about the service. We contacted the local authority, local Healthwatch and commissioners to ask their views about the care provided at the service.

We inspected the service on the 22 and 28 July 2014. At the time of our visit there were 34 people living at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at all areas of the service and spent some time looking at documents and records that related to people's care and the management of the service. We looked at five people's care records.

Over the two days of our inspection we spoke with 12 people living at the service and four relatives of people who used the service. We spoke with ten staff. On the second day of our inspection we spoke with the Registered Manager and looked at management records that had not been available at our first visit as the Registered Manager had not been at the service.

Inadequate

Is the service safe?

Our findings

At our previous visit we found that people were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. At this visit we saw that a new system of medicines storage and administration had been introduced. Medicines were now safely stored in people's own rooms. However, the service's medicines policies and procedures had not been reviewed and updated to provide clear guidance to staff about the new arrangements for the safe handling of medicines.

Appropriate safeguards were not in place for the covert (hidden) administration of medication. A DOLs (Deprivation of Liberty Safeguards) application for the covert administration of medication had been made without reference to a report stating that the individual had the capacity to choose not to take medication. The nurses on duty told us that covert administration had stopped following the report, but current medicines administration records were still annotated "covertly". Additionally, we found some creams in people's rooms that were not included on their current cream application record. It was unclear whether these creams were discontinued or should still be applied.

Medicines were administered by qualified nurses. However, arrangements had not been made to ensure that special label instructions such as, 'before food' were followed, or that the minimum required time was left between repeated doses of medication. A nurse told us that this was to be discussed at the next nurses' meeting. Written individual guidance about the administration of 'when required' was on occasion missing. This meant there was no clear guidance for staff administering medicines about how each person should be supported to make sure they received their 'as and when required' medicines as intended by the prescriber. A stock of a 'when required' medicine for hypoglycaemia (low blood sugar) was not available for one person who had previously required this medicine to manage symptoms of their diabetes.

The medicines administration records were generally clearly presented to show the treatment people had received. However, people's medicines were not well managed on admission or re-admission to the home from hospital. For example, one person experienced a delay of six days in starting a new medicine. A request for new supplies of a prescribed supplement for a second person was only made two days after they, "Ran out". There were 'gaps' in the record keeping for a third person where medicines administration or the reason for non-administration was not recorded.

We found that the service's medicines arrangements did not protect people against the risks associated with medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous visit we had found there were not always enough staff to provide support to people. At this inspection people and their relatives told us there were insufficient staff and they felt that this impacted on the safety of people who lived at the service.

We spoke with the relatives of one person who were concerned about injuries sustained by their family member including bruises on their legs and forehead as well as a gash on their forearm. They told us they did not believe any of the injuries were non-accidental but felt that a shortage of staff and lack of supervision meant that no one witnessed the incidents that had occurred or was present to prevent them. They were most concerned as their family member had been involved in an incident where another person had sustained an injury. We had been made aware of this incident prior to our visit and had asked the general manager about the plans in place to prevent further incident. They told us their risk assessment had led to staff always being present when both people were in the same room. We completed observations in the lounge during the afternoon and noted frequent periods of 10 to 20 minutes when there were no members of staff present but both people were in the lounge together.

A relative of another person said, "The staff are pushed to the limit; I think they do well under pressure."

The general manager explained the staffing rotas provided a nurse on duty at all times. From observation and in discussion with the nurse there appeared to be a shortfall in the number of nurses required, with one nurse covering both units. At our first visit the nurse on duty, who was also the clinical lead, was occupied with nursing tasks and liaising with visiting health professionals leaving no time for anything else. One visiting health professional told us they had been supported by a member of the care staff as the

nurse had not been available to support their visit. Nursing staff told us they felt the care staff did not have all the skills required to deliver essential care interventions and this put additional pressure on the qualified staff.

Night staff told us there were not enough staff to support people and told us about one person who woke early but was not able to get up until more staff came on duty at 8am as they needed two staff to support them to get up. We raised this with the registered manager who told us this was not the case but they were supported in bed for longer as they were at risk of falling.

Some support to people was provided in a task oriented rather than person centred way. During our SOFI observation we saw people were brought to the lounge and then left in their wheelchair. Three people were then later transferred from their wheelchairs to an easy chair one after the other. This was an example of a routine that benefitted staff rather than people who used the service.

At our first visit of this inspection we observed the lunchtime service on both units. On the first floor unit we observed some people waiting almost half an hour for their lunch. One person was supported by a relative. We found staff were stretched and were reliant on a volunteer who was supporting several people at once to eat their lunch. On the second floor those people who needed assistance were helped to eat although this meant people had to wait as only two care staff were giving this assistance and several people required help.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment records showed appropriate recruitment practices had been followed and pre-employment checks had been completed before staff started work at the service. This reduced the risk of the provider employing staff who were not appropriate to work with vulnerable adults.

People we spoke with told us they felt safe. Staff we spoke with recognised abuse and described the actions they would take if a person was subjected to abuse.

Nursing staff told us in the event of an incident of abuse they would ensure the person was safe and protected before contacting the manager; if they were not available they would follow the service's guidance. However, they were unable to readily give us a copy of the procedure they would follow. On the first day of our inspection we found a copy of the Leeds Multi-Agency Protection Procedures 2002 in the staff room. This document was out of date and no longer relevant. The general manager told us there was no copy of the West Yorkshire Multi-Agency Safeguarding Adults Policy and procedure 2013 available at the service. This meant there was no copy of the relevant documentation to guide staff through the safeguarding process. However, at our second visit we were shown a copy of the relevant document that was available in the staff room.

Staff we spoke with were clear they did not use restraint or holds when supporting people with their personal care. Where people were supported in ways that could be regarded as other forms of restraint such as the use of bean bags and recliner chairs, applications had been submitted for a Deprivation of Liberty Safeguards authorisation. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards protect the rights of people who lack capacity to consent to care and treatment when their rights are restricted in order to keep them safe. This is a requirement of the Mental Capacity Act 2005.

There was a lack of information regarding other requirements of the Mental Capacity Act 2005. There was a mental capacity assessment in one person's file but this did not record the specific decision that was being assessed. Training information showed staff had not received training regarding the principles of the Mental Capacity Act. This meant there was an increased risk of staff not acting in a person's best interests where they did not have capacity to make decisions for themselves.

We saw that risks were considered for people in relation to their physical care needs. Where people were at risk due to their mental health needs, records were not always detailed enough to help staff avoid an escalation of behaviours.

On the first day of our visit we raised concerns that there were no personal evacuation plans available detailing how people should be supported to evacuate the building in the event of a fire. We raised this with the general manager who confirmed there were none in place. Following our visit we contacted the fire service to raise our concerns with them. At our second visit we were shown copies of personal evacuation plans. The nurse in charge told us the fire evacuation plan had been, "Updated last week", but was

Inadequate

Is the service safe?

not available. A fire officer attended the service on the second day of our inspection and arranged to return at a later date. We spoke with the fire officer following their return visit who told us they were satisfied with the arrangements in place in the event of a fire.

On the first day of this inspection we found areas of the service were not clean and this increased the risk of cross infection. We found bathrooms were used to store all hoist slings on hooks where the slings touched each other. It was not clear which slings had been laundered and were being stored and those that were in regular use. We also noted three bath and shower chairs were soiled.

We checked mattresses and found three that were stained and soiled. One mattress was of particular concern. We checked the most recent mattress audit which took place on 7 July 2014 and saw that this had not identified any issues with the mattress. We raised this with the general manager during our first visit. At our second visit we checked the person's bed and found the mattress had been replaced.

At our second visit of this inspection we noted a significant improvement in general cleanliness. Carpets were being shampooed and those areas where we had raised concerns had been addressed. Following our visits the provider contacted us to explain they had reviewed their arrangements for the storage of slings and that these would now be stored in people's bedrooms reducing the potential for cross infection.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us they received induction and on-going training. The training file showed subjects for 2014 training, that had been provided prior to our visit, included moving and handling. Additional themed training had been provided specific to people's needs. This included dementia awareness, care planning and nutrition and dining. There was no evidence of plans for staff to complete Mental Capacity Act 2005 training.

Staff employed by the service told us they received supervision. Records confirmed this. However, we observed some poor practice when completing a lunchtime observation relating to how people were supported to eat and drink. This included people being supported two at a time, people having their mouths wiped with their spoon and being told, "Come on; open up", and "Good girl." When we raised this with the general manager they told us the person providing support was a volunteer and not a staff member. When we asked what support was provided to volunteers to make sure they acted in accordance with the standards of the service the general manager stated there was nothing they could do to monitor or address practice issues as they were a volunteer. We explained we would expect volunteers to be provided with the support required to maintain consistency and standards of care.

People we spoke with told us the food was good and they had enough to eat and drink. Relatives of people who used the service who we spoke with were all positive about the food and drink provided and the assistance given. We observed the lunchtime service on both units. On the second floor people were offered a choice of meal. On the first floor the only available option was salmon. An option of chicken arrived after people had been served their main course. This meant people on the first floor had reduced choice on the day of our inspection.

We spoke with the chef who told us they prepared alternatives where people did not want the available choice. They told us, "Some people don't like fish but I know what they like. Today they have had chicken and salad." The chef was aware of the dietary requirements of people who used the service. They explained one person had dietary needs related to their religious practice as well as people whose dietary requirements were related to their health needs.

The chef confirmed they were kept informed of changes in people's weight. They told us they had identified trends where people lost weight at the same time and this was thought to be seasonal. They explained the actions they had taken to address this.

Care records did not contain information to use in the event of a person requiring admission to hospital. In one person's file we saw a document named 'All about me and saying goodbye'; however, this was blank. Hospital/ communication passports are recognised good practice, particularly when supporting people living with dementia to transfer between services. As the document was blank there was a risk that in the event of a medical emergency there would not be time to populate the document with the relevant information about the person's life story and personal needs/preferences that would remain unchanged and might improve the continuity of care for the person as they transferred to other services.

People had access to the local GP and other professionals as required. Records showed people had support from health professionals to help them with their physical and mental health needs. Where people had been visited by members of the multi-disciplinary team, the outcome of their visits was recorded on the person's file. This meant staff were able to access the most recent clinical advice for the person. On the first day of our visit a tissue viability nurse and dietician visited the service. The dietician explained they were reviewing eight people as part of their visit.

One person who used the service said they had no problems getting to see the dentist.

We spoke with a visiting health professional who told us that although they usually gave a specific appointment time in advance, people were rarely ready for their visit. They told us that staff generally followed the advice given.

Requires Improvement

Is the service caring?

Our findings

We observed some positive interactions between staff and people who used the service but this was not consistent. Some care staff spoke in an abrupt manner whilst others did show compassion and understanding. All staff were seen to knock on bedroom and bathroom doors before entering, however they did not wait to be invited in.

We observed one person ask three different care staff for something. Although the first staff member said, "I will go tell them" it was not clear they understood what the person wanted or who they were going to tell. A second member of staff said, "Can't have a shower; not today"; again it was not clear this is what the person had asked for. The staff responded with no warmth. A third member of staff understood the person and went to get them a tissue. However, they brought several tissues back with them and started handing them out to other people as well. They said to one person, "Do you want one?", again with no warmth or politeness.

There was little seen in terms of explanation of what was about to happen when using moving and handling equipment. At one point the senior staff member on the second floor attempted to place a person's feet on the foot rests of their wheelchair. The brakes were not applied to the wheelchair which therefore moved as attempts were made. The staff member did not explain what was happening or what they were trying to do.

The same sling was used to hoist three different people. One of these people pulled a face as if they were in pain when they were being hoisted but nothing was said by the staff. During the hoisting only instructions were given out by staff; there was no checking to see if people were okay or general conversation. This was also reflected on a separate occasion during our SOFI observation where three people were seen to be supported to transfer from their wheelchair to an easy chair. For one person the only interaction was where staff gave instruction but no explanation of what they were doing. The only comments made by staff were, "Put your feet on there for me: Sit forward then: Watch your fingers: That's it hold on tight: Are you ready we are going up now: Let go then that's it." When the person called out as if in pain the staff member told them, "It's alright you won't fall." This was not said in a reassuring or empathetic way.

In one person's care records it was clear one of the triggers for their behaviour that challenged could be staff attempting to provide care interventions. From our general observations of care for all people who used the service, it was apparent there was minimal explanation of what was going to happen or information for people of what was planned before they were moved or approached. This could potentially increase the risk of people being resistant to personal care interventions.

One person waiting in their wheelchair to be assisted into their armchair was making a noise and needed their mouth cleaned; this was done carefully and once in their chair they became settled. However, whilst they were being hoisted we heard the care staff say to them, "You need a wash." This manner did not promote the person's privacy or dignity. Despite care staff identifying the need for assistance with their personal hygiene this was not provided.

People were not involved as partners in their own care. One person told us they would like a bath or shower every day but got one twice a week. Another person said they were worried about their bowels and had been given some tablets but then they had been taken away. They appeared anxious about this and had no explanation as to why their medication had changed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Positive examples of care provided included one person being supported with a new battery for their hearing aid when they were struggling to hold a conversation and another person whose clothing was rearranged during their transfer to ensure their dignity. On the day of our first visit the weather was very hot; staff asked people if they were too hot and opened windows, one very frail person was cold so staff covered them with a blanket. People we spoke with told us the staff were kind.

People's friends and relatives were able to visit freely. One visitor brought a dog in which seemed a great favourite with people who used the service. They told us they came every day and everybody knew the dog and enjoyed seeing him.

Requires Improvement

Is the service responsive?

Our findings

Nursing staff told us they did not use a nursing assessment and the information for planning and assessment of need came from a pre-admission document; the general manager and not a nurse usually completed this.

Some people were subject of a 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) order. The general manager explained each person had a red dot on their care records indicating they had a DNACPR. This was done to minimise the risk of people being resuscitated against the instruction of the order in a medical emergency. However, in one person's care record we found a DNACPR was in place but there was no indicator on the spine of their file. We saw a DNACPR form in the care records for another person but the only mention of the DNACPR being in place was a hand written entry under the statement 'I do not have a DNR on file'. This increased the risk that the person would not be treated in accordance with their DNACPR in the event of a medical emergency.

Care records contained a general risk summary. This had been completed on admission and reviewed. However, it was not clear when any changes had been identified or the risk summary updated.

Within the care records reviewed there were no specific risk assessments and plans for monitoring people's well-being and how to help them live well with dementia. We asked nurses how they monitored the progression of a person's illness. They told us this was not something they did at the service.

One person's care plan referred to diversion as a technique for staff to use when helping them to manage their anxiety and associated behaviours. Whilst the plan gave staff guidance about the care interventions required it was not clear exactly what their behaviours were and how much risk the person presented to others and themselves. In discussion with a nurse it became apparent there had been a change in their behaviours due to a deterioration in their mental health; however, we could not find any documentation which recorded and responded to people's changing needs.

Reviews of care plans were limited and were not easy to find. Plans were numbered and the daily record made reference to these; there was no clear summary of the evaluation of plans. Phrases like 'no change' and 'care given as plan' were regularly used. As the entries were made into the daily record it was difficult to read about what had been happening for the person in relation to specific care plans. One nurse told us if they could change one thing it would be the records.

On a ground floor notice board there was a plan of activities for July. Although this provided information to people who were entering and leaving the building it was not accessible to people who chose to remain on the units.

Care records had an activity profile which gave an oversight of the activities people liked to do, however this was not reflected in any plans. On reviewing the on-going record it was difficult to identify any social activities or outings. We spoke with one person who did not have any hobbies but said they looked forward to going out and had been taken out the week prior to our visit. They told us they wished they had more company but that everyone was kind.

The service employed an activities coordinator. They explained they divided their time between the service and a sister service. We observed them facilitating indoor activities during the morning. In the afternoon we saw people were supported to access the garden area. An external activities facilitator came in the morning to provide activities such as singing and playing the tambourine. People involved in this activity were engaged and appeared to thoroughly enjoy the session.

A volunteer from the local Black Elders group visited the service on a regular basis. This allowed people who used the service to maintain close links with their community.

Nursing staff told us they were aware of how to handle any complaints that were raised with them.

Complaints were investigated and resolved with the nature of the complaint, the actions required and the actions taken recorded. However, prior to our inspection we had been contacted by a person who had made a complaint regarding the care of their relative who alleged they had been responded to inappropriately and had felt threatened. They told us the registered manager had accused them of acting in an abusive way towards their family member. This allegation had been escalated to the local authority safeguarding team by the general manager as part of a wider investigation.

During our inspection the service forwarded a copy of a complaint response they had made to another person who

Requires Improvement

Is the service responsive?

had made a complaint regarding the care of their relative whilst at the service. Again, as part of their response the registered manager had made an allegation that the complainant had acted in an abusive way towards their family member. The complaint response suggested the complainant should reconsider their complaint rather than provide a full response to the concerns raised. These responses risk people feeling they cannot raise concerns and complaints rather than encouraging complaints be used to facilitate improvement at the service.

Other relatives we spoke with told us they had not complained but said they knew there was information about how to complain available. One relative of a person who used the service said they had no complaints but if they had, they would speak to the manager and would not feel concerned about raising a complaint. Another visitor said they knew who was in charge and how to complain. They told us, “They always say tell us if anything is wrong. I’m always talking to staff and give feedback; we have a good rapport.”

Inadequate

Is the service well-led?

Our findings

Although the service had a registered manager they were also a company director of the provider organisation and as a result were not based at the service on a full time basis. Prior to our inspection the general manager had overseen any notifications that had been submitted to CQC in relation to people's care and welfare. On our arrival at the service on the first day of our inspection, the registered manager was not present but the general manager was at work.

At the initial visit there were no records available relating to quality monitoring, training, or supervision. Following our initial visit we were contacted by the registered manager who told us the records were not available when they were not at the service as they did not want anybody else to have access to them.

The general manager was clear there were no personal evacuation plans available to inform staff of their actions in the event of a fire. Although actions were taken to fit evacuation equipment and review fire evacuation plans prior to our second visit this was done in response to our concerns rather to proactively review the safety of people who used the service.

Our observations showed there was little compassion offered to people and that some staff did what they had to; we did not see evidence of team working. There was little joined up communication and staff seemed to work in isolation of each other. This meant some people had to ask several staff for assistance before they received the support they required.

Four relatives of people who used the service raised concerns with us regarding the leadership and communication at the service. One relative who had raised concerns regarding unexplained injuries and the management of their family member's behaviour told us they had raised concerns with the service but these were not being responded to promptly and that there was a lack of supervision and continuity of information between staff and managers.

A relative of another person who used the service expressed concern about staffing levels and communication telling us, "We haven't had any feedback at all; we don't know what's happening."

A third relative explained their family member had sustained a serious injury in a safeguarding incident. Although they told us they were generally happy with the care their family member received they said that in relation to the safeguarding incident, "I got second hand information about what had happened."

A fourth relative told us that the week prior to our visit they had a call from a member of staff to say they were having difficulty getting their relative to go to bed and they were refusing to allow staff to deliver personal care. The relatives were told a decision had been made to put a DoLS authorisation in place but, despite being told someone would phone them about this, they had heard nothing. When they phoned to enquire no-one seemed to know what was happening. The member of staff they had originally spoken to was not in and nobody else was able to deal with their queries.

Although a system for the management of medicines had been implemented six weeks prior to our visit of 22 July 2014 the service's medicines policy and procedure had not been updated. At our second visit we were shown a copy of the original policy that had been sent to the registered manager by fax transmission on 23 July 2014 with handwritten notes. Before we completed our second visit we were provided with the new policy that the registered manager told us had been finished that morning. However, the policy document was dated April 2014. This was not an accurate representation of the review of the medication policy.

Care records were sectioned and had an index. The condition of the record files was variable and one folder was falling apart. The evaluation of care plans was mixed into the daily record, which made it difficult to track how care was progressing. Nursing staff were unable to find records of best interest discussions and decisions they told us had taken place. We also found care records had not always been updated when people's needs had changed.One nurse told us if they could change one thing it would be the records. They explained they would like to see the evaluation of each plan with the plan and not mixed in to the daily entry. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Nurses told us they did not have support with their continued professional development. They told us nurses did not receive regular supervision or the opportunity for

Inadequate

Is the service well-led?

clinical discussion. The units did not have regular formal staff meetings, although one nurse told us they would get staff together to discuss changes in care plans. We saw a training matrix had been completed for 2014 that suggested regular supervisions were carried out.

During our observations we had noted concerns about the attitude and approach of a staff member who was abrupt in their manner. As part of our inspection we had asked for a random selection of recruitment files to check people were recruited safely. We noted in the same staff member's file this had been an issue that had been addressed with them over a several year period. The general manager told us they had recently been disciplined for similar issues relating to their attitude and approach. This showed action to address concerns regarding the attitude and approach of the staff member had not been effective.

During the morning we had approached another member of staff to ask about the alternative choices for people who did not like the option on the menu for lunch. They responded with, "Yes it's salmon; the choice is you can take it or leave it." This raised concerns that if formal visitors were responded to in this way people who used the service were likely to encounter similar inappropriate responses.

It was of particular concern that both staff identified were team leaders and were the example for other care staff at the service. We raised this with the general manager who told us this might be an issue about culture or humour. We disputed this as a reasonable explanation for the behaviour observed.

There was not an open culture within the service where staff and people who used the service were encourage to raise concerns in order to drive improvements. One complaint response was defensive and contained personal information relating to the registered manager that was not appropriate to share. The provider's response to complaints would have prevented people from raising any concerns in the future. The whistleblowing policy, rather than encouraging staff to raise concerns, stated that any malicious whistleblowing would be subject to disciplinary action.

Although audits had been completed in line with the provider's clinical governance and annual quality plan for 2014 they had not identified some of the concerns we raised at our visit. This included concerns related to infection control. Where audits had raised concerns they had not been addressed. This included the need for 'as and when required' protocols relating to the management of people's medicines. This had been identified by the provider in March 2014.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **How the regulation was not being met:** **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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **How the regulation was not being met: The registered person did not make suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **How the regulation was not being met: The registered person did not have effective systems in place to monitor the quality of service delivery. Regulation 10 (1) (a) (b) (2) (i) (ii) (d) (I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	How the regulation was not being met: The registered person did not ensure that service users were protected against the risks of unsafe or inappropriate care or treatment arising from a lack of proper information about them by means of the maintenance of - an accurate record in respect of each service user including appropriate information and documents in relation to the care and treatment provided to them. Regulation 20 (1)(a)<Provide Judgement Summary>