Roseberry Care Centres GB Limited

Haythorne Place

Inspection report

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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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

A scheduled inspection took place on 26 August 2015. The inspection was unannounced which meant the staff and provider did not know we would be inspecting the service. A scheduled inspection took place on 26 August 2015.

The service was last inspected on 9 September and 10 September 2014. At the last inspection we found the service was not meeting the requirements of the following regulations: care and welfare of people who use services and assessing and monitoring the quality of service provision. As a response to the last inspection the provider sent a report to the Care Quality Commission of the action they would take to become compliant with the regulations. The provider told us they would complete the actions for care and welfare of people who use services and assessing and monitoring the quality of service provision by the 31 December 2014.

Haythorne Place is a nursing home for up to 120 beds. The service is divided into six houses. One house accommodates younger people with physical disabilities, another house specialises in people with mental health problems. Four houses accommodate older people. Two of these provide support for people living with dementia. At the time of the inspection there were 118 people living at the service.

Summary of findings

There was a registered manager for this service in post at the time of the inspection. The registered manager was on annual leave at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were not protected against the risks associated with the unsafe management of medicines. We shared our concerns with deputy manager and regional manager during the inspection.

The provider had not ensured that an accurate, complete and contemporaneous record in respect of each person was maintained.

We found that some people had not received appropriate care. We shared our concerns regarding people's individual care with the senior member of staff on duty in the house, the deputy manager and the regional manager.

People told us they felt safe and were treated with dignity and respect. People were satisfied with the quality of care they had received and made positive comments about the staff.

Relatives and people's representatives felt their family member or friend was in a safe place. Relatives gave mixed views regarding the quality of care their family member had received.

People's individualised diets were being met. We received both negative and positive comments about the quality of the food.

We observed some staff giving care and assistance to people throughout the inspection. People were respectful and treated people in a caring and supportive way. However, we also observed some staff were focussed on tasks and did not check on people's wellbeing or check if they required assistance.

Although our discussions with staff told us they were aware of how to raise any safeguarding issues, we found the provider had failed to ensure the service effectively operated systems and processes to protect people from abuse and improper treatment.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. This meant people were cared for by qualified staff who had been assessed as suitable to work with people.

The provider had failed to ensure that there were sufficient staff deployed to meet the needs of people and that staff received the appropriate training to enable them to carry out the duties they were employed to do.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We found that staff were not following the code correctly. We shared this information with the deputy manager and regional manager.

People were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.

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

The overall rating for this service is "Inadequate" and the service is therefore in "Special measures". Services in special measures will be kept under review and if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of

Summary of findings

inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Although people told us they felt safe we found some people's individual risk assessments were incomplete and/or inaccurate. In some cases it was difficult to ascertain whether they were still current.

The service did not have appropriate arrangements in place to manage medicines so people were not protected from the risks associated with medicines.

We found the provider had not ensured that there were sufficient levels of staff in each house to enable support to be delivered in a timely manner.

Is the service effective?

Requires Improvement

The service was not always effective. People's comments captured during the inspection showed the system in place to offer a choice of at meal times required improvement.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). However, we found two examples where the MCA and associated code of practice had not been followed properly.

We found there was not a robust system in place to ensure staff received training and support for them to deliver care and treatment safely to an appropriate standard.

Is the service caring?

Requires Improvement

The service was not always caring.

People made positive comments about the staff and told us they were treated with dignity and respect.

During the inspection we observed some staff giving care and assistance to people. They were respectful and treated people in a caring and supportive way. However, we observed some staff who were focussed on tasks, did not check people's wellbeing or check if they required assistance.

Is the service responsive?

Inadequate

The service was not responsive.

At our last inspection we found the provider had not ensured that all the people living at the service had appropriate care and support to meet their needs. At this inspection we found sufficient improvements had not been made.

Summary of findings

We found that some people's records were not maintained to ensure they were accurate, complete and contemporaneous. We found that some people living at the service were not receiving the appropriate care to meet their needs.

Some people's records showed that there was a risk that some people's behaviour was not managed consistently and the risks to their health, welfare and safety are not managed effectively

Is the service well-led?

Inadequate

The service was not well-led.

At the last inspection we found the provider had not ensured that appropriate checks were completed to assess and improve the quality of the service. At this inspection we found sufficient improvements had not been made.

There was not a robust system in place to assess, monitor and mitigate the risks relating the health, safety and welfare of people.

The provider had failed to ensure that each person at the service had an accurate, complete and contemporaneous record which included a record of the care and treatment provided to each person.

Haythorne Place

Detailed findings

Background to this inspection

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

A scheduled inspection took place on 26 August 2015. This was an unannounced inspection which meant the staff and the provider did not know we would be visiting. The inspection team consisted of two adult social care inspectors, two specialist advisors and two experts by experience. Both specialist advisors were registered nurses who were experienced in the care of older people. 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 experiences had experience of older people's care services.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from the local authority, Commissioners and Healthwatch. Healthwatch had visited the service on 16 March 2015. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted an external healthcare professional and a social worker.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We spoke with 22 people living at the service, six relatives and one person's representative. We also spoke with one visiting healthcare professional, the regional manager, the deputy manager, four nurses, 14 care assistants, two laundry assistants, two administrators, an activities co-ordinator, a cook and a kitchen assistant. We looked round different areas within each of the houses; the communal areas, the kitchen, bathroom, toilets and where people were able to give us permission, some people's rooms. We reviewed a range of records including the following: nine people's care records, people's medication administration records, six staff records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People spoken with told us they felt 'safe' and had no worries or concerns. Peoples comments included: "it feels safe, waiting for help depends, sometimes a long time sometimes not", "it's quite nice, I feel safe" and "if I had a problem I'd tell the nurse on duty – would get sorted".

Most relatives spoken with felt their family member was in a safe place. However, a few relatives felt the safety of their family members could be improved by to ensuring there was enough staff to meet their family member's needs in a timely manner.

People had individual risk assessments in place. For example, a falls risk assessment and nutritional risk assessment. However, we found examples of incomplete risk assessments, the incorrect scoring of people's individual risk and in a few cases we were unable to establish whether the person's risk assessment was still relevant and current. We also saw that there was not a robust system in place to ensure people's risk assessments were reviewed in a timely manner and evaluated at the same time as care plans so they could be used to inform the care plan. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. The reviews we looked at did not demonstrate what information had been used to inform the review or how the person and their relatives were involved in the process. We shared our findings with the deputy manager and regional manager.

During the inspection we observed that a person had damaged the furniture in their room. For example, a wardrobe had been pulled from the chain anchoring it to the wall and an armchair had been pushed against the wall, breaking the arm of the chair and damaging the wall. We spoke with the staff on duty in the house; they were unable to provide much information. One staff member commented: "I was told about it yesterday but didn't have time to check it out". During the inspection the damaged furniture was removed from the room. This showed the person had not been supported in a timely manner to maintain a safe environment in their room.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and related records such as patch rotation charts.

In the sample of MARS and relating records checked we found concerns. For example, we found one person's transdermal patch application did not have the name of the person for whom it was prescribed for, no patch name or strength. A transdermal patch is a medicated patch that is placed on to the skin to deliver a specific dose of medication into a person's bloodstream. We also saw there were two missing entries on their chart for two days in August 2015. Another person was prescribed a patch to alleviate pain. We found there was no patch rotation and no monitoring of its effectiveness. It is important that an accurate, complete record in respect of each person's medication administration is maintained.

Where staff had failed to sign confirmation that the medication had been administered we checked the person's stock of medicine to ensure they had received their medication. However, we were unable to check a medicine for one person because it was from a bulk prescription. A bulk prescription is an order for two or more people bearing the name of a service in which at least 20 persons normally reside, 10 or more of whom are registered with a particular GP practice. The provider had obtained bulk prescriptions for medicines such as lactulose and Senna, so we were unable to check whether they had received the medication. When medicines cannot be accounted for, it is impossible to tell whether or not they have been given correctly.

We found that a few medicines were not always kept securely. For example, we observed in one of the houses that the safe storage of thickening powder was not maintained. The thickener was kept in an unlocked cupboard in a kitchenette. The kitchenette had a coded lock but we saw on three occasions during the morning that staff left the door unlocked. Tins of thickener should be stored away safely as they present a risk to people if the contents is swallowed.

We saw that the placement of the Controlled Drugs cupboards in some of the houses required improvement to

ensure appropriate access to staff. For example, in one of the houses the cupboard was located just inside the door of the medicines storage room, near to the floor so it was difficult to access and to see in the cupboard.

We also found that the provider did not have an adequate system in place to ensure the denaturing and disposal of control drugs was carried out. For example, in one of the houses we found two controlled drugs dated July 2013 which were not in use, not denatured and not returned. We spoke with the nurse in charge of the unit; they told us the house did not have a denatured kit. Staff use a denaturing kit to render controlled medicines irretrievable and unfit for further use until they are returned.

We found the arrangements in place to ensure medicines were stored at the right temperature required improvement. For example, in one of the houses there was no thermometer in the medicines storage room. We saw staff were recording a temperature for the room even though there was not a thermometer. In the same house, we saw the temperature of the drugs fridge was not checked on a regular basis to ensure drugs were being stored at the right temperature. When medicines are not stored within safe temperature ranges this can impact on how effective they are.

Many people living at the service were prescribed medicines to be taken only "when required" for example, painkillers and medicines for anxiety. Information was not consistently available for care workers to follow in order to ensure that the medicines were given correctly and consistently with regard to the individual needs and preferences of each person. For example, how a person expressed they were in pain. Records showed that some people living at the service were not administered any "when required" medication during a cycle and this had not been reviewed to ensure they were being appropriately supported.

One person received a medicine that required a full glass of water to be taken with the medication. We found that there was no guidance in place to ensure these special measures were followed. It is important to have this guidance in place to ensure the person is not placed at a risk of harm.

Some people needed to take their medicines at times to ensure they were given before food for best effect. We saw that some of the arrangements in place were not individualised around the person's routine. For example, some people required a medicine to be taken a minimum of thirty minutes before food for best effect. The current arrangements in place were for the night staff to give people this medicine to people at 7am even if they had breakfast at 9am.

We found that systems in place to check how well medicines were managed at the service were ineffective in practice. It is essential to have a robust system of checks in place to order to identify concerns and record the actions taken to make the improvements and changes needed to ensure medicines are managed safely. We shared our findings regarding the management of medicines for individual people with the deputy manager and regional manager.

These findings evidenced a breach of Regulation 12 Heath and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service had procedures in place to manage people's spending accounts to safeguard people from financial abuse. We spoke with one the service's administrators. We checked a sample of three people's receipts against their spending account on the provider's computerised accounts system and found they corresponded. This showed that staff followed the provider's procedures.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. It was clear from discussions with staff that they were aware of how to raise any safeguarding issues. However, we found the reporting and investigating of incidents required improvement. There were systems and processes for staff to follow but they were not effectively operated to prevent abuse of people living at the service. For example, we found the service had not responded appropriately to the risks between two people. We found an incident has not been investigated appropriately when an injury had occurred. The incident form signed off by manager stated it was an unwitnessed injury. However, daily records showed that the injury was the result of an altercation between two people; the incident had been witnessed by a domestic worker.

Some people living at the service had behaviour that could challenge others. We found that the provider had not ensured that challenging behaviour charts were used to look for patterns in a person's behaviour and when aggressive behaviour occurred. For example this could be verbal aggression, noting down everything that was going

on at the time that could have triggered the behaviour. This told us there was a risk that some people's behaviour was not managed consistently and the risks to their health, welfare and safety are not managed effectively. For example in one person's records there was no indication on how to minimise the impact of the person's behaviour on them or others living in their house.

We also noted that some of the entries made by staff describing people's behaviour were judgemental and opinionated. For example, a staff member had recorded "[name] has been in a nasty mood provoking other service users" and "she is in argumentative mood and very contrary; responding to auditory hallucinations". This showed that some staff working at the service required additional training in supporting people with behaviour that could challenge others. This showed that people may be at risk of receiving improper care.

These findings evidenced a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We received mixed views from people regarding the staffing levels within the service. We found people's views varied because they lived in different houses within the service. Some people spoken with did not express any concern about the staffing levels within the house they lived in. They were supported by regular staff who knew them well. However, some people expressed concerns about the staffing levels in their house and the level of agency staff being employed at their house. Comments from people who lived in house five included: "no not really [staff to meet people's needs], last night only a nurse and two carers", "you have definitely got to wait if I press the button [call bell]. Ten minutes or so usually" and "a couple of weeks ago it was 5 past 9 when I rang to go to the toilet, it was 10 past 11 when I got on the toilet".

Some relatives expressed concerns about staffing levels in house five and the level of agency staff. They also were concerned about the impact this was having on their family member and the continuity of care. Their comments included: "not enough staff" and "no, I come every day and there's like two [staff] on, not enough" and "she [family member] has a call button, it's on the side (out of reach). She can use it; sometimes it takes them some time to get here if called".

We received mixed views from staff regarding the staffing levels within the service. Some staff did not express any concerns about staffing levels. Staff working in house five expressed concerns about the staffing levels in their house. Their comments included: "not enough, no", "definitely not enough staff", "it is an absolute joke" and "we are frequently short staffed, mainly due to unplanned last minute sickness like this morning". Staff also told us that only one qualified nurse worked across house five and house six at night. The nurse was responsible for administering medication in both these houses. Staff told us that the drugs round started at 8:30pm and often was not completed until 11:30pm. There were 20 people living in each house. The round could be interrupted if a person required assistance or should an incident occur. The houses at the service are not linked electronically so care staff have to phone or physically leave the building to summon for assistance leaving one care worker with the person requiring assistance and the other people in the house. We shared our concerns with the deputy manager and regional manager.

Staff working in house six also expressed concerns about staffing levels. Staff comments included: "we have three carers and a nurse in the mornings and could do with four plus a nurse as sometimes the nurse has to cross cover all houses" and "only two care workers in the afternoon – physically can't do it". One relative spoken with told us about a recent visit to their family member in house six. They found their family member sitting in bed, their clothing and bed was wet as their family member had not been supported in a timely manner with regards changing their continence wear.

We reviewed the service's agency usage form for week commencing 24 August 2015. We saw that agency nurses were mainly being used to cover shifts within house five and six. On the night shift an agency nurse was being employed to cover house five and six on the 26 and 27 August 2015. We reviewed the previous three weeks usage and saw that it was common practice for a nurse to cover both houses at night.

These findings evidenced a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Each house at the service had its own cleaning schedule. We found that house five had malodours. This told us that the cleanliness of the house was not being maintained. We

Inadequate

Is the service safe?

also saw the arrangements in place to clean syringes in the kitchenette were not appropriate. A small lounge used by smokers in house five was fitted with an extractor fan but we found this was not effective at cleaning the air. We found that house four also smelled strongly of smoke, this showed the arrangements in place to clean the air in this house were also ineffective. We shared these findings with the deputy manager and regional manager; they assured us they would take action to address these concerns.

During the inspection, we noted there were some hazards within the service that presented a risk to people. For example, in house five a missing rubber seal was missing on the floor which presented a tripping hazard. Clothes were being stored inappropriately so they caused a tripping hazard. We saw staff had used a fire extinguisher to prop open a fire door. We shared these findings with the deputy manager and the regional manager; they assured us that these concerns would be addressed.

We found some concerns regarding the monitoring and maintenance of equipment. For example, in house five, eight people had fridges in the rooms. Staff spoken with told us that the temperatures of these fridges were not monitored.

During the inspection we saw that one person was not supported in a timely manner because a piece of equipment was not working in their house. We spoke with deputy manager and regional manager about the importance of having contingencies in place regarding equipment.

We found the arrangements in place to ensure the maintenance of lifts and the call bells were in working order at the service needed to be more robust. During the inspection the lift in house three was not working. Staff told us the lift repeatedly stopped working. We also received information that the call bells in one of the houses had not been working. The deputy manager and regional manager assured us that the issue regarding the lift was being resolved and the lift contractor was waiting for parts. They informed us that the call bell in one person's room was the only call bell that was not working now and observation checks on the person had been put in place.

We reviewed four staff recruitment records. The records contained a range of information including the following: application form, job description and references including one from the applicant's most recent employer. The provider had completed a Disclosure and Barring Service Adult check for each staff member. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. We also saw evidence where applicable that the nurse's Nursing and Midwifery Council (NMC) registration had been checked and was current.

Requires Improvement

Is the service effective?

Our findings

In people's records we found evidence of involvement from other professionals such as doctors, optician, tissue viability nurses and speech and language practitioners. People told us they saw the doctor when they needed to. An external healthcare professional was visiting people at the service on the day of the inspection. They told us that if the service had an agency nurse working during their visit, the agency nurse did not know people as well so could not always answer the questions they asked about the person readily. They suggested that a permanent member of staff was rotared to work on their regular visits to the service.

People's comments captured during the inspection showed the system in place to offer a choice of at mealtimes required improvement. People's comments included: "not really, they don't ask you what you want, they just bring it [meal]", "no, they don't give you a choice, you have to have what they have. I've not seen a menu around here, they [staff] usually come at half past twelve and say we've got so and so or so and so, that's the only choice".

We spoke with the cook, they were aware of people who had allergies or required a specialist diet and/or soft foods. The cook showed us details of each house's weekly meal ordering form. The form showed where people had chosen something different from the menu. The sheets also gave information about people with individualised diets. For example, fork mashable or pureed.

We spoke to a member of staff in one of the houses, they told us that people's meal choices were gathered on a weekly basis and showed us a weekly chart where people's options were listed as A or B. The staff member was unable to show us a menu. We saw there was a large blackboard marked "menu" on the in wall in one of the dining areas but this was blank. We spoke to a staff member in another house regarding the arrangements for choice at mealtimes. The staff member commented: "when it [meals trolley] comes across, we ask them [people] what they want; it depends on what they are capable of eating too". The menu board was blank in the dining room.

We received mixed views from people about the quality of the food. Some people were satisfied with the quality of the food provided at the service. People commented: "we had a nice dinner today", "food's lovely – fish and chips on Friday", "very good food, I like everything about it. It's lovely food" and "foods alright, I miss steak". One person suggested there was cordial and fruit available for people in the houses.

Some people spoken with were dissatisfied with the quality of food. People commented: "wouldn't say it was good and wouldn't say it was bad – mediocre", "rubbish", "the food's unappetising, foods horrible, I buy my own some days", "I like spicy food, don't get asked if I like the food", "not keen on the food – quality's poor, basic food" and "food's terrible – only fish and Sunday dinners are worth eating". One relative spoken with was dissatisfied with the quality of the food and rated the food out of ten as a four. We shared this feedback with the deputy manager and regional manager.

During the inspection we observed the arrangements at mealtimes in two of the houses. In one of the houses most of the people living there came to the dining room to eat lunch. They were asked where they preferred to sit and some chose to stay in the lounge area. Tables were laid with cutlery and a table cloth, there were no napkins or condiments, some people had clothes protectors on. We saw the menu board in this house had been completed. People were offered a choice off the board. The lunch time was very quiet; there was little or no conversation. Staff made sure people were sufficiently close in to the table. We observed a staff member supporting a person to eat, giving the person time to try to eat before they provided support. We saw people sitting in the lounge being encouraged to eat by staff.

We observed the arrangements at lunch time in another house. Meals were served in a small dining room and in a dining area off one of the lounges. We observed one staff member shouting meal choices over people's head to another staff member from the dining area. We saw that staff did not ensure that one person was sufficiently close to the table in the dining area and that all the people had been served a drink to go with their meal. We spoke with a staff member and pointed out that two people had still not received a drink. There were no condiments available for people to use. During the meal we noticed that staff focussed their attention on serving different courses rather than checking if people needed assistance. Where people were not eating we saw there was little encouragement or support provided.

Most staff spoken with told us they felt supported. Staff commented: "I can talk to the cook or managers, there is

Is the service effective?

always someone around", "I can get my point across and feel listened to", "manager takes things on board, can go to them if there is anything we want to talk about", and "manager is very supportive" and "I like my job I don't have any problems. You can go to the manager with anything and she will help you". However, in houses where agency nurses regularly worked, staff told us they did not receive the same level of support as they would from a permanent member of staff. One staff member commented: "I don't feel supported by management".

Staff files showed there were some inconsistencies on the level of supervisions provided to staff. Supervision is the name for the regular, planned and recorded sessions between a staff member and their manager. It is an opportunity for staff to discuss their performance, training, wellbeing and raise any concerns they may have. We saw examples where staff received regular supervision and examples where supervisions were less frequent. We saw that supervisions focussed on specific issues and information sharing rather than the staff member.

We reviewed the services staff training spread sheet and we saw there was a system in place to highlight when staff required refresher training. We saw that a range of training was being provided to staff to reflect their role at the service. This included: nutrition and hydration, fire safety, safeguarding vulnerable adults, health and safety, food hygiene and infection control, moving and handling. The spread sheet showed that some staff at the service had not been provided with appropriate training when they started working at the service. For example, one nurse who started working at the service in January 2015 had not completed training in the following areas: fire safety, safeguarding vulnerable adults, moving and handling, health and safety, nutrition and hydration and Mental Capacity Act 2005. A medication competency assessment had also not been completed. A care worker who started working at the service in May 2015 had not completed training in moving and handling, infection control, nutrition and hydration, food hygiene and fire safety. This showed that the provider had not ensured that all staff received appropriate training as is necessary for them to carry out their duties.

The training spreadsheet also showed that only a small percentage of staff working at the service had attended challenging behaviour training. In the last year only four staff had completed the training. Some staff had completed the training in 2007 and 2008. Our findings and observations during the inspection showed that some staff demonstrated a lack of understanding in supporting people with challenging behaviour. For example, we observed a person upsetting other people sitting in the lounge who were trying to hear the television. The person was constantly talking or singing. We did not observe any distraction techniques being used by staff or see staff attempting to speak and engage with the person.

These findings evidenced a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that some areas within the service required refurbishment. We saw that some progress had been made in some of the houses. For example a care worker showed us two bedrooms that had been decorated in one of the houses. We noticed in different houses that door numbers were missing and numbers had been written on the doors or on the door frame. In houses where people living with dementia lived we saw there was no directional signage for people. There were no memory boxes to orientate the person to their personal space and doors were the same colour. We reviewed the service's "environmental wish list". We saw that this "wish list" did not reflect the National Institute for Health and excellence (NICE) guidance for dementia friendly environments. The guidance states the providers should ensure environments are enabling, aid orientation and include attention to lighting, colour schemes, flooring coverings, signage, garden design and access to safe external environments. The corridors were very narrow in five of the houses. We observed in one of the houses that the drugs round was frequently interrupted to enable staff to pass with other equipment or people being supported in a wheelchair.

The main lounge area in house five was being used to store equipment which did not make it a pleasant environment for people to sit in. For example, a mattress, a wheelchair, a specialised chair and a walking frame was being stored in the lounge. We also saw people's clothes hanging on hangers from the hand rail in the main reception areas, which presented a tripping hazard. We also saw clothes hanging outside two of the rooms. The upstairs lounge in house five was being used to store equipment and laundry. We saw that this lounge area could not be used by people

Requires Improvement

Is the service effective?

living in the house. Staff spoken with told us this lounge area was not used much. We shared this information with the deputy manager and regional manager; they assured us that these concerns would be addressed.

The Mental Capacity Act (MCA) 2005 is an act which protects and promotes the rights of people who are unable to make all or some decisions about their lives for themselves. It promotes and safeguards decision-making within a legal framework.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We saw examples where people had been supported to make decisions in accordance with the MCA. We looked at two people's DoLS applications and authorisations. We saw that a mental capacity assessment had not been completed prior to an application being made which showed staff were not following the MCA code of practice correctly. A mental capacity assessment had subsequently completed by the local authorities best interest advisor. We spoke with the deputy manager and regional manager regarding the importance of following the code to ensure people are appropriately supported.

Requires Improvement

Is the service caring?

Our findings

People spoken with made positive comments about the staff: "they're [staff] alright with me, they look after me I'm right happy with them", "can talk to staff, it such a homely place", "they're [staff] better than my relations, they're excellent here", "staff are alright here, easy to talk to if you've got a problem- they're ready to listen to you. Have a joke with them" and "staff are more than excellent with every resident here. They listen to you; they don't just fob you off, got the time of day for you". One person told us there were a lot of bank staff working in their house. They commented: "got a lot of bank [staff], carers and nurses and they're okay".

People could choose where they liked to eat their meals. People could choose to stay in their room or go and sit in the lounge areas. During the inspection we saw a few people going to the main office to speak with the administrators.

Most relatives spoken with did not express any concerns about the way their family member was treated by staff. One relative felt the interaction between staff and people could be improved. They commented: "I hear them [staff] talk to some people as though they are kids".

People's records showed that their next of kin or relatives were not routinely involved in the reviews of care plans. For example, in one person care records the last entry of involvement was in January 2014.

People told us they were treated with respect and that staff were mindful of people's privacy. Some people living at the service chose to lock their rooms. People commented: "yes, get privacy okay – carers get to know my needs. My key worker will discuss things with me, when she's on she'll sort things out" and "privacy, that's okay. I haven't a fault to find. I've never heard them [staff] grumble about a patient". During the inspection staff were observed to knock on doors prior to entering.

Staff spoken with told us they enjoyed working at the service. Staff comments included: "I like my job, it's challenging and people's conditions can change. It's very rewarding", "people want staff with a smiling face and that is what they get", "I enjoy my job, it's a challenge to see what you can do and achieve to help people", "my job is nice, I like supporting people with mental illness, and each day is different which makes it pleasant", "this is a good home people really do care, I would be happy for a family member to live here" and "I love coming to work". Care staff spoken with were able to describe people they supported and their individual preferences. One staff member commented: "staff know people that live here really well; we know their background and their family".

During the inspection we saw examples of staff communicating with people effectively. The staff used different ways of enhancing communication by touch, ensuring they were at eye level with people who were seated and altering the tone of their voice appropriately. We observed warm and good humoured interactions between staff and people. However, we also saw examples where staff's focus was on completing tasks, providing very little interaction or checking on people's wellbeing. For example, we observed one person sitting alone in their wheelchair at a table in a dining room. A staff member brought in their breakfast. The staff member simply placed the food in front of the person and left. The person was not offered a napkin or condiments. The staff member had not made sure the person was seated close enough to the table. We saw the person had difficulty getting food from the plate to their mouth as they were too far from the table. The person asked for our assistance to move them closer to the table.

We also found entries made by staff in some people's records who had behaviour that could challenge others was judgemental and/or opinionated. This demonstrated that some staff working at the service lacked an understanding in supporting people living with conditions that affected their behaviour.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the provider had not ensured that all the people living at the service had safe and appropriate care and support to meet their needs. The provider submitted an action plan following our inspection which detailed the actions they intended to take in order to achieve compliance. At this inspection we found the provider had not made sufficient improvement.

People spoken with told us they were satisfied with the quality of care they had received. People's comments included: "it gets top gold marks – I'm well looked after, kept clean and well fed" and "feel safe, they're all very kind, I'm quite satisfied, and they'll do it if they can".

We received mixed views from relatives and people's representatives regarding the quality of care their family member had received. For example, some were very satisfied with the quality of care provided. Their comments included: "quite pleased with the care, very satisfied overall" and "the care is good, the staff are wonderful, and it is a very nice nursing home". However, some relatives were dissatisfied with aspects of the care their family member had received. For example, one relative was concerned about the cleanliness of the house their family member lived. Another relative felt that there was a lack of activities provided for people to do. Another relative thought the quality of the food provided could be improved.

We found that some people's records were not maintained to ensure they were accurate, complete and contemporaneous. We found that some people living at the service were not receiving the appropriate care to meet their needs. For example, one person started living at the service in 2013. We saw most of their care plans had been completed on admission or more than a year ago. We saw that risk assessments were not evaluated at the same time as care plans so they did not have any impact or relevance to informing the care plans. In the person's records we were unable to find the results of a blood test completed at the beginning of 2015. Their falls risk assessment did not indicate the level of risk; it had been evaluated on the 31 July 2015. The person was weighed monthly; however their last recorded weight was in April 2015. Their pressure area risk assessment was incorrectly scored for their current age. Their nutritional risk assessment was scored incorrectly. Their eating and drink plan written in October 2013 and last evaluated in July 2015 states "food intake monitored", "eats on the go" and "staff to ensure she is getting adequate diet". We spoke with a care worker they told us that the person's food and fluid intake was not monitored as they ate and drank well.

During the inspection we saw that the advice provided by a palliative care nurse regarding one person's pain management had not been actioned by staff, following their visit on the 19 August 2015. We spoke with the nurse in charge, they did not know about the advice. During the inspection the nurse contacted the person's GP to obtain further advice.

Some people's records showed that there was a risk that their behaviour was not managed consistently and the risks to their health, welfare and safety were not managed effectively. For example, one person's "this is me" record stated they were deaf on the left side so talk to their right side. This was not mentioned in their communication care plan. In the person's daily records on 25 August 2015 it stated: "she is disorientated to time and place and continually went out of the fire escapes, encouraged to return. Safety issue". This was not mentioned in the person's risk assessment for leaving the house. There was no advice to care staff as to how to manage this risk.

Another person had a chart to monitor incidents relating to behaviour. There were three incidents recorded between the 30 July and the 15 August 2015. The person's daily records showed that a further incident on the 9 August 2015 had not been recorded on the person's chart. A review had been completed on the 17 August 2015, we saw no evidence that these incidents were used to inform the review and evaluate the care plan or whether this was an increase in these episodes. The entry read "staff to monitor and document behaviour".

These findings evidenced a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service had two activity coordinators. Staff told us that one of the coordinators had been absent from work for some time. People's comments regarding the activities included: "It's the same thing, day after day", "had one or two outings, not so many recently, staff shortages I think"

Inadequate

Is the service responsive?

"I'm a walker, always have been, they do take me out, they know I like walking and they do take me out. I'm going with one of them this afternoon, I like to walk out with someone" and "there's not much to do".

We reviewed the services spring newsletter dated May to July 2015. It gave details and pictures of the trips people had participated in. For example, house two had a trip to the monkey forest, six people visited Bakewell and six people had visited Coronation Street tour in Manchester. It also gave details of events that had been held at the service or were planned to be held. For example, an entertainment evening in September 2015. However, we found the arrangements in place in place to ensure people in all the houses were provided with daytime activities to promote their wellbeing required improvement. We observed that people in the most of the houses were provided with little stimulation. This can lead to people becoming disengaged with their surroundings.

The services complaints process was on display in each house of the service. The complaints process advised the person or their representative to initially contact the staff member in charge of the house which maybe an agency nurse. One person spoken with told us about their experience with raising concerns. They commented: "to get things changed you have to badger them [staff] a bit, they're helpful in small doses". One relative spoken with told us they had escalated their complaint to the manager's level; they found the registered manager had no knowledge of the concerns they had made to senior staff in the house their family member lived in. This showed the system did not always ensure complaints were picked up at management level. This meant management may not be aware of the nature of some of the concerns being raised by people or their representatives to staff for them to act on accordingly. This information was shared with the deputy manager and regional manager

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the provider had not ensured there was an effective system in place to regularly assess and monitor of the quality of the service provided. The provider submitted an action plan following our inspection which detailed the actions they intended to take in order to achieve compliance. At this inspection we found that sufficient improvements had not been made.

There was a registered manager in place at the service; they were on annual leave at the time of the inspection. The deputy manager was managing the service during their absence. As part of the action plan to improve the service, the provider had stated that the home manager and/or senior staff would be conducting daily walk rounds. We saw that a safe environment was not being maintained in one of the houses and in a person's room. We saw that equipment was not being stored appropriately in houses. There was also concerns regarding the lift and calls bells not working in one of the houses.

Our findings during the inspection showed that the system for monitoring the management of medicines was ineffective. It is essential to have robust monitoring in place in order to identify concerns, to make improvements and changes needed to ensure medicines are managed safely.

Senior managers were aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. However, there was not a robust system in place to assess, monitor and mitigate the risks relating the health, safety and welfare of people. Our findings showed that incidents were not consistently reported and/or effectively investigated. This also showed that the systems and processes to safeguard people from abuse were not being effectively operated.

The provider had failed to ensure that each person at the service had an accurate, complete and contemporaneous record which included a record of the care and treatment provided to each service user. This showed that the system in place to audit care plans was not robust.

The system in place to ensure staff there were sufficient numbers of competent, skilled and experienced staff required improvements. We found that the system in place to ensure staff received mandatory training and specialised training to meet the needs of people living at the service was ineffective in practice.

We reviewed the resident and relatives meeting minutes held in the house. Five meetings had been held at the beginning of 2015 and one meeting had been held in June 2015. We saw there was not a system in place to ensure that a meeting was held regularly at each house or an agreement when the next meeting would be held. We noted in the qualified nurses meeting in August 2015 that an instruction had been given to hold a residents and relatives meeting before 10 September 2015.

We saw the service's questionnaire to relatives in 2014 had been collated. In the questionnaire results some relatives stated that they were not involved with six monthly care file reviews. We saw there was no action listed to address this concern. People's records showed that people's relatives were not being actively involved in reviews. The provider had stated in their action plan that surveys would be circulated as a minimum 6 monthly with themed surveys where the service was looking at specific areas or based on any concerns raised. We saw no evidence to confirm that further surveys had been completed.

These findings evidenced a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the last staff meeting minutes for each house. The time the meetings took place ranged from January 2015 to April 2015. We saw that a standard agenda was not used for the meetings and the topics discussed were dependant on the chair. For example, one meeting covered a range of topics including: personal bedding and laundry, people's oral hygiene, untidiness and documentation on all charts, hoists and call bells. Another meeting had two topics, basic care and work environment. This showed there was a lacking of consistency or oversight by senior managers working at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. The provider had failed to assess the risks to the health and safety of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider had failed to effectively operate systems and processes to protect people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had failed ensure that there were sufficient staff deployed to meet the needs of people. The provider had failed to ensure that staff received the appropriate training to enable them to carry out the duties they are employed to do.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met. The provider had not ensured that people received care and treatment that was appropriate and to meet their needs.

The enforcement action we took:
The service was placed in special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Service users were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision. The provider had not ensured that an accurate, complete and contemporaneous record in respect of each service user was maintained.

The enforcement action we took:
The service was placed in special measures.