Gainford Care Homes Ltd

Lindisfarne CLS Nursing

Inspection report

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Ratings

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

Overall summary

This inspection took place on 14, 15 and 21 October 2014. This was an unannounced inspection, which meant that the staff and provider did not know that we would be visiting.

Lindisfarne CLS Nursing provides nursing and personal care for up to 56 service users. The home is arranged over two floors, both of which cater for people with dementia type illness with the first floor providing services for males only. During our inspection on 14, 15 and 21 October 2014 there were 29 service users at the home, 14 of whom were accommodated on the first floor.

The provider is required to have a registered manager at this home as condition of their registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Although we found that the provider had appointed an acting manager, when we visited on 14, 15 and 21 October 2014 there was not a registered manager in place nor had CQC received an application for a manager to be registered at this home since November 2013.

At our previous inspection carried out on 9, 10, 22, 24, 29, 30 July and 7 August 2014 we found the home was in breach of the following:

Regulation 9, Care and welfare of service users,

Regulation 11, Safeguarding service users from abuse,

Regulation 12, Cleanliness and infection control,

Regulation 15, Safety and suitability of premises,

Regulation 20, Records.

The provider was issued with a Warning Notice in respect of each of these areas.

At this inspection we found that improvements had not been made to meet these requirements and Lindisfarne CLS Nursing was inadequate in all areas we inspected.

We looked at guidance for providers in dementia care including the following:-

- The National Institute for Care Excellence (NICE) 'Dementia Supporting people with dementia and their carer's in health and social care 2006;
- Alzheimer's Society Fact Sheet 2013. Staying Involved and Active
- The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance' and
- The NICE guidelines 'Pressure ulcers: prevention and management of pressure ulcers 2014'

The provider had failed to take account of this guidance.

We found peoples care and welfare needs were not properly met at this home. People who had dementia care needs did not have them properly met at the home. For example people who displayed behaviours which challenged staff or other service users because of their dementia type illness were not supported by staff in a consistent or well-planned way. Detailed intervention plans for when people became agitated were not in place and best practice guidelines to help avoid these circumstances were not considered. Medicines that have a sedative effect on people were found to be used in some circumstances without guidance or sufficient agreed practice to safeguard and protect service users' rights.

Responses, strategies and preventative measures for people who had become sexually disinhibited because of their dementia type illness were not in place at the home. There were no detailed or organised plans in place for people who were likely to display these behaviours placing them and others at risk.

People were at risk of poor nursing care at the home. Nurses did not demonstrate that they had an understanding of peoples nursing care needs or were taking actions to meet them. For example some people had pressure ulcers but nurses on duty did not know this and their care plan records gave inconsistent and contradictory information. Some people at the home had life limiting or multiple illnesses but nursing staff did not know about them; did not know what impact this had on their daily needs; nor did they have packages of care in place to support these needs.

Some people required support with their diet so that they could remain as healthy as possible. Care planning for people who needed support with their diets was not sufficiently detailed or was contradictory. The weight and condition of people with dietary needs was not routinely measured to make sure support was working or not and kitchen staff were not involved in supporting people with these needs. Nursing staff also omitted to make sure peoples' nutritional support medicine was available and in stock at the home.

We found that peoples' mental health care needs were not understood or supported at the home. For example if people had been subject to treatment and support under the Mental Health Act 1983 the provider did not carry out an assessment of their mental health needs or demonstrate their best interests, rights or care and welfare were protected at the home. Staff were not aware of which people in the home were subject to detention under this Act.

Staff recruitment procedures at the home were not safe. Recruitment records at the home did not demonstrate

Summary of findings

that service users were protected from those who were unsuitable to work with vulnerable people. For example thorough background checks, including those to make sure applicants had not been legally barred from working with vulnerable adults or children had not been carried out; nurses legal status (registration with professional bodies); and if people from abroad were eligible to work were not checked.

Staff deployment was inconsistent or inaccurate, for example some staff were recorded on the homes rota as working there but in practice were regularly working at another home. We found that the and the provider also failed to regularly assess the needs of service users in relation to overall staffing levels and monitor the services provided. For example we found one nurse and two care staff were allocated to look after 29 service users who had both nursing needs and displayed challenging behaviour. Key staff were also inappropriately organised at the home. For example the home required deployment of nurses who had both mental health and general nursing qualifications all times but the staff rota did not ensure staff with these skills were on duty.

Staff training records had not been compiled and ordered. The provider could not demonstrate the level of training staff had received or how this met the needs of the home or service users. Training in key areas such as how to support people with behaviours that challenge staff or other service users, could not be demonstrated.

The provider did not take measures to safeguard service users who were likely to harm themselves or place themselves in situations which may cause them serious injury or risk of death. For example we found two serious incidents had taken place where the provider had failed to put in measures to reduce the likelihood of harm. We made a safeguarding alert to Durham County Council during the inspection as we were concerned about the provider failing to protect one person's health.

We found that people were not protected from the risk of infection. Furniture, equipment and surroundings of bedrooms and communal areas were not properly cleaned and there was poor odour control. We found that in a significant number of areas of the home appropriate standards of cleanliness and hygiene were not maintained. This demonstrated that cleaning had not been carried out effectively other procedures used at the home placed service users at risk of infection.

There was a lack of adequate maintenance to the home which meant that service users were not protected against the risk of unsuitable or unsafe premises. For example mobility aids were insecure, furniture was in danger of falling on people, windows did not work properly and refurbishment work had not been completed. One person's bedroom fire door did not close properly putting them at risk if there was a fire. Combustible materials were being stored in the stair well emergency exit which could have become blocked in the event of a fire. Fire evacuation plans were unsafe and neither the nurse in charge nor care staff knew what to do in an emergency.

The provider did not effectively assess and monitor the quality of the home to make sure it was safe, effective and meeting the homes 'Statement of Purpose'. The home had a 'Quality Assurance Policy' but both the acting manager and area manager could find 'nothing in place.' Other areas of monitoring such as the frequency of accidents and incidents and the measures to reduce risks to people living at the home could also not be found. An annual plan to ensure a quality service and residents and relatives surveys were not carried out.

Complaints at the home had not been handled properly. For example responses to complaints by a relative had not been made and this was not recorded in the homes complaints file.

Other monitoring of the home had not taken place. For example, at the July 2014 inspection we made the provider aware that the ambient room temperature of the home were excessive. At this inspection we found the home to be again excessively warm however no monitoring had taken place and no remedial action had been taken to ensure the ambient temperature of the home remained in line within Health and Safety guidelines.

We found that the provider failed to make improvements to the quality and safety of services for people at the home. The provider did not take action following a CQC inspection on 9, 10, 22, 24, 29, 30 July and 7 August 2014 where the home was found to be in breach of five regulations and people using the service were found to be at risk despite Warning Notices being issued. The provider did not act in a timely fashion to achieve compliance, meet service users' needs and adequately protect them from receiving poor care. Although the

Summary of findings

provider had taken steps to appoint an acting manager and area manager, approximately five weeks before this inspection, their impact on the service was limited and we found the provider remained in breach of regulations which warranted further enforcement action to be considered.

The provider did not have key policies in place which would support staff to take effective measures to care for people being accommodated at the home at the home.

For example the homes response to incidents where staff were required to restrain service users for their own safety were not supported by clear policy and procedural guidance.

We found there were multiple of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We are taking action in line with our enforcement policy outside of this inspection process.

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?
The service was not safe.

We found staff had not been safely recruited and where some staff had indicated they had committed offences these were not followed up or risk assessed to see if they were safe to work with vulnerable people. We found there were insufficient numbers of staff to meet the needs of the people that used the service.

We found the home was insufficiently clean to reduce the risk of the spread of infection and the provider did not have in place a robust arrangement for managing maintenance of the premises. The building was not maintained to an appropriate standard.

We found that the provider did not take measures to safeguard service users who were likely to harm themselves or place themselves in situations which may cause them serious injury or risk.

Inadequate

Is the service effective?
The service was not effective.

We found the provider failed to make sure staff maintained an accurate record in respect of each service user, which include appropriate information and documents in relation to the care and treatment provided to each person.

We found guidance issued by professional and expert bodies was not put in place at the home which placed people at risk of poor treatment and care.

We found peoples mental health needs were not known about, understood or monitored at the home in relation to Deprivation of Liberty Safeguard Authorisations and where people had previous treatment under the Mental Health Act 1983 legislation.

We found staff did not have the training needed to meet people's needs.

Inadequate

Is the service caring?
The service was not caring.

We observed instances where people at the home who needed individual medical treatment did not receive this in a caring or respectful way.

We found some people's rooms had no personal possessions or no individual items at all. This did not demonstrate that peoples' previous lifestyles, significant experiences and personal history were known about and valued by staff.

We saw some people who needed support with eating were treated in a caring way with staff describing food types before giving it to them.

Inadequate

Is the service responsive?
The service was not responsive

Inadequate

Summary of findings

We found there was a lack of person centred care for those people at the home who have dementia. Where people had behaviour which challenged staff or behaviour that was sexually disinhibited their care planning was not sufficiently robust to consistently guide staffs practice. Where care plans were in place these did not follow published guidance.

We found peoples' nursing care needs were not understood or supported at the home. People with complex medical conditions were not understood and routinely supported and reviewed.

We found that there were no therapeutic activities at the home which would provide interest or stimulation and help promote positive behaviour and improve service users' wellbeing.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager at the home for over a year and the provider did not routinely check that the service being provided there was fit for purpose and met the needs of service users.

We found the provider did not monitor or assess the service and had not ensured that people who used the service were safe, received effective, caring and responsive services which met their needs.

The provider had failed to respond to CQC enforcement action. The provider did not make improvements to the quality and safety of services for people at the home a timely fashion in order to adequately protect them from receiving poor care.

Lindisfarne CLS Nursing

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 14, 15 and 21 October 2014.

The inspection team consisted of five Adult Social Care inspectors with specialisms in mental health care, dementia and recruitment; and a specialist advisor whose specialism was in nursing care for older people.

Before this inspection we reviewed notifications that we had received from the service and a recent report from the County Durham Prevention and Infection Control Team. We also reviewed information from people who had contacted us about the service since the last inspection, for example, people who wished to compliment or had concerns about the service.

Before the inspection we obtained information from a Strategic Commissioning Manager and Commissioning Services Manager from Durham County Council, a Commissioning Manager and an Adult Safeguarding Lead Officer from Durham and Darlington Clinical Commissioning Group, Safeguarding Practice Officer and Safeguarding Lead Officer of Durham County Council, an Expert Practitioner for mental health and older persons, and a Lead Infection Control Nurse.

During the inspection we spoke with eight people who used the service and nine of their relatives. We had unstructured interviews with eleven staff including the deputy manager, acting manager and area manager. We also spent twelve hours observing practices within the home and we also reviewed relevant records. We reviewed ten peoples' records including their care plans, risk assessment, medication information and other associated records. We looked at 10 sets of recruitment records and the staff training records, as well as records relating to the management of the service.

For this inspection, the provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

The acting manager confirmed that a dependency assessment tool (a means for deciding how many staff are needed to support people who used the service) was not used at the home. There was no information to show how monitoring of the dependency level of people who used the service was carried out. We looked at all of the information relating to staff deployment, over a seven week period. We found that some staff were recorded as being on shift at Lindisfarne CLS Nursing but had worked their shifts at other homes owned by the provider. From discussion with staff it was found that this was a regular occurrence and often the home had less staff on duty than reflected in the rota. For example when we visited the home on 15 October 2014 (nightshift,) one nurse and five night staff were due to work at the home. One care staff member phoned in sick and one care staff was recorded as working at Lindisfarne Birtley, which left a nurse and three care staff to look after the 29 service users who had both nursing needs and displayed behaviours that challenged the service. We found that the staff were routinely moved in this way to different services without there being due regard for the safety of those at Lindisfarne CLS Nursing and the provider failed to regularly assess staffing levels and monitor the services provided.

We asked the acting home manager and the administrator for any accident and incident monitoring information. Staff were unable to produce this information and the acting manager confirmed that they could not find any such documents and were not aware that any had been produced. This meant that the provider had failed to establish if people were at risk of accidental injury, failed to identify any trends or put in measures to reduce risks to people living at the home.

This is a breach of Regulations 22 (Staffing) and 10 (Assessing and monitoring the service) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We looked at nine staff recruitment records and found no evidence of a Disclosure and Barring Service (DBS) check for three people, two of whom were employed as nurses at the home. We saw two staff had been employed without evidence of a DBS check being carried out prior to their appointment where both application forms indicated they had a criminal record. However there was no indication that their suitability to work with vulnerable people had been risk assessed to make sure they were suitable for their job role. The acting manager was unable to provide us with an explanation. In other staff files we found there were gaps in documentation including no application forms, no references and no identification checks.

This is a breach of Regulation 21 (Requirements relating to workers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Guidance issued by professional and expert bodies such as the National Institute for Care Excellence (NICE) guidance 'Dementia Supporting service users with dementia and their carers in health and social care' 2006 was not in place at the home. We found medicines that have a sedative effect on people were found to be used in some circumstances without guidance or sufficient agreed practice to safeguard and protect service users' rights. For example, we did not find evidence of actions staff should take to prevent people from becoming agitated or descriptions of any triggers, thresholds where medication should / should not be given or alternative techniques / strategies. The nurse in charge, acting manager and area manager agreed that these were not in place.

This is a breach of Regulation 9 (Care and welfare) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that the provider did not take measures to safeguard service users who were likely to harm themselves or place themselves in situations which may cause them serious injury or risk of death. We found two serious incidents had taken place where prior advice had been given to personnel in charge of the home that service users had indicated an intention to place themselves at serious risk. Despite the provider being aware of the risks we found they had failed to take account of these service users' needs and put in measures to reduce the likelihood of harm. We made a safeguarding alert to Durham County Council during the inspection as we were concerned about the provider failing to protect one person's health.

At our previous inspection we found the temperatures in the building to be excessively warm. At that time the provider failed to deal with the excessive heat and this lack of action led to service users not being protected from harm. At this inspection we found the temperatures in the building to be again excessively warm but no action was to identify why the temperatures remained excessive. When

Inadequate

Is the service safe?

we visited we found service users were awake and active in the home from 6am but were not offered drinks of any form until breakfast at 9.30am. We also noted that all of the water coolers located throughout the home had no cups and were not used. During the inspection we found that the ambient temperatures were excessive but no remedial action to reduce the risk of dehydration by providing access to extra drinks. We found that the provider failed to protect service users from neglect and staff inaction placed service users at risk of harm.

This is a breach of Regulation 11 (Safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We found that people were not protected from the risk of infection. We looked at all bedrooms that were in use, all bathrooms and communal areas of the home and found that in a significant number of areas of the home appropriate standards of cleanliness and hygiene were not maintained. For example both sluice commode disinfection machines were out of order. Soiled bedpans were stored inside them and the air extraction fans did not work. Odour control was ineffective, the armchairs in peoples rooms and some communal areas, were stained with a brown / yellow residue and dried drip like marks around the perimeter of the under seat surfaces. We found some service users' wheelchair cushions were found to be stained and were not clean.

We found mattresses in six service users' bedrooms were stained / soiled. Other beds or bedding equipment was found to be damaged making it impossible for them to be cleaned effectively or had not been cleaned effectively. One persons' duvet was soiled but despite this, had been had been made up by staff for continued use. This demonstrated that cleaning had not been carried out effectively other procedures used at the home placed service users at risk of infection.

This is a breach of Regulation 12 (Cleanliness and infection control), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We found that procedures which should have been in place for dealing with emergencies were inadequate. For example we reviewed the fire evacuation plans and found that three were in use which all contained different information about who was living at the home. None of the lists of people on these plans was accurate. Neither the nurse in charge nor care staff knew how many people were residing at the home at the time of our inspection. Staff were unable to explain what consideration they might need to give if they needed to assist people to leave the building in an emergency. The night nurse could not tell inspectors where the fire alarm control panel was located so if the alarm was activated by a fire, its location could not be known.

There was a lack of adequate maintenance to the home which meant that service users were not protected against the risk of unsuitable or unsafe premises. For example the handrails in two toilets were loose in their fixings making it difficult for service users to use safely. Taps in several bathrooms were loose or did not work, temperature control equipment was insecure and shower areas were not sealed properly. Free standing wardrobes were not fixed to the wall and could fall over and some of the windows in peoples' bedrooms did not seal / close properly making it difficult to control the temperature. Emergency call alarm cords were missing or inaccessible so people would be unable to call for assistance. One person's bedroom fire door did not close which would have made it ineffective in the event of a fire. Combustible materials were being stored in fire escape routes.

This is a breach of Regulation 15 (Safety and suitability of premises), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Two relatives we spoke with commented positively. Referring to the standards of cleanliness one person said, "In the last few weeks there has been big improvements." Another commented, "The place is cleaner since the new manager came in."

Inadequate

Is the service effective?

Our findings

We reviewed the staffing rotas and saw that the deployment of nursing staff did not lead to there being an adequate skill mix to meet the needs of service users at the home. For example either two general nurses or two mental health nurses worked together rather than having one of each skill set on duty each day. We asked the acting manager and the regional manager for information to show how skill mix was determined but they were not able to produce any and stated they believed this did not exist.

This is a breach of Regulations 22 (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We were advised by the acting manager and area manager that staff training records had not been compiled and ordered. No training information had been compiled which would demonstrate the level of staff training overall or how this supported the services aims or peoples' needs. We found that none of the records were in order and could not establish if they related to current staff. We also saw that training information included staff who had left employment at the home and did not include those who were recently employed. We also looked at six staff files and found these contained no information about recent training they had undertaken or any supervision or appraisals sessions completed in the last year.

We reviewed training files for all of the nurses currently employed at the home and found these contained no information about any competency checks completed or checks that they remained on the NMC register. There was no information in these files to confirm they had completed the required number of hours training they needed to maintain their nursing registration. Also there was no information to confirm they had the competency to meet the mental health nursing needs of the service users who displayed behaviours that challenge; nursing needs of service users with a dementia type condition; or service users' physical health needs.

We found the 'Statement of Purpose' for the home indicated that the home provided a service to 'protect vulnerable service users from potentially agitated and disinhibited men.' However the acting manager and area manager confirmed that staff were not provided with training to assist them deal with this client group for example dealing with behaviour that challenges; breakaway techniques; or physical intervention training. None of the care plans we looked at detailed how to physically intervene if service users became aggressive and service users had no protection against the risk of unlawful, or otherwise excessive, physical intervention being used.

This is a breach of Regulation 23 (Supporting workers), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that incidents of service users displaying aggression and becoming assaultive occurred and at times staff had to protect themselves and service users from assaults. We looked at the homes physical interventions policy, which was entitled "Policy on Non Restraint" which stated, "The company policy is not to use any form of restraint". However we saw that staff used a recliner chair to limit one person's ability to get up and walk freely and we found that sedative medication was routinely used to reduce service users' agitation and aggression. We also found from a review of a behavioural incident where staff had needed to physically separate service users, physically prevent services users assaulting them by taking hold of their arms and had used "as required" medication. This did not follow the company policy but no further actions had been taken. For example there had been no safeguarding referrals; no action was taken investigate the incidents; additional supervision or support to staff was not provided nor was a review of whether, in light of the company policy, these service users' needs could be met.

This is a breach of Regulation 9 (Care and welfare) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked for information to show how the provider made sure Deprivation of Liberty Safeguard Authorisations remained in date and were updated as expiry dates neared. However the acting manager could not provide this information and we found that no system existed to monitor compliance with legal requirements or statutory duties. We sampled care records which indicated that service users had previously been subject to actions under the Mental Health Act (MHA) 1983 legislation. However there was no information contained in care records to indicate what had led health care professionals to detain service users or what the risks to themselves or others they

Is the service effective?

posed and why this was of such severity that it warranted them being detained under MHA legislation. There was no evidence that a further assessment of their mental health needs had been completed since they moved to the home.

This is a breach of Regulation 18 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that the lack of accurate and consistent documentation in relation to the provision of nutritional support, made effective treatment by nurses unlikely and placed service users at risk. We found that the kitchen staff were not routinely given information about service users dietary requirements. For example the diet sheets were found to be in the dining area and were incomplete and were not signed by the nurse in charge. Some service users with nutrition needs did not have a diet sheet. There were no records to show that kitchen staff knew what service users' dietary needs were or which service users' had been prescribed supplements. Care staff working in the first floor 'male only unit' were not aware of diet sheets at all. We found that care plan records were also not completed where service users were at risk of malnutrition. For example one person had a record which stated they had weight loss and that supplement drinks had been prescribed, however there was no evidence of a food intake diary or weekly weight monitoring. Another person was at risk of malnutrition but there was no evidence of weight monitoring, assessments or food charts. In one person's care documentation their diet was described as 'normal'. However in another document we found they were described as being diabetic. We saw the medication administration record (MAR) for the home which showed that one person had been prescribed with a nutritional supplement to be administered three times per day. However the MAR showed that this had not been administered for a period of eight days because of a stock ordering problem and no alternative or emergency medication had been acquired.

This is a breach of Regulation 20 (Records) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that although the home stated it was designed to provide care for people experiencing dementia recognised guidance had not been followed in respect of creating a dementia friendly environment. Therefore we saw no evidence that the provider had considered how to support people to remain as independent, as possible, through the use colour and materials. For instance using contrasting colours on the toilet doors and toilet to make it easier for people find them and using colour to make it easier for people to make their own way around a unit.

This was a breach of Regulation 17 (Respecting and involving service users), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw records to confirm that people had visited or had received visits from the dentist, optician, chiropodist, dietician and their doctor. However we found that the nursing staff were unaware of people's physical health conditions. For instance did not know which people had pressure ulcers, whether people were at risk of experiencing malnourishment or had conditions such as cancer that may need monitoring. This lack of knowledge meant staff were not in a position to make referrals to other health care professionals when individual's conditions changed.

This was a breach of Regulation 24 (Cooperating with other providers), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One relative said since the new manager has come in, "the girls are more cheerful and happy." The felt their relative was then happy in herself and found her to be well cared for and always clean.

Inadequate

Is the service caring?

Our findings

We observed instances where people at the home who needed individual medical treatment did not receive this in a caring or respectful way. For example, we observed one service user having a medical examination in the lounge area with other service users and visitors present. Staff did not intervene nor did they take steps to protect this person's dignity when they were in a state of undress.

We saw service users' receiving chiropody treatment in the ground floor lounge which was also being used by other service users and visitors. Staff did not put measures in place to protect peoples' privacy and dignity, suggest or facilitate other areas where treatment could take place.

We spoke with the nurse in charge of the 'male challenging behaviour unit' about what best practice guidelines were used to assist staff to meet the needs of the people accommodated there. The staff member said, "I would try to find triggers. Men mishear or misunderstand staff or other residents. Noise can be a trigger so I take them to another area. If it doesn't work I take them to another room. The last thing I would try is medication." However, we found no evidence in the care plans we reviewed or from formal observations in the units that triggers were identified and steps taken to eliminate them or reduce their impact. None of the care staff that we spoke with on this unit could outline the triggers for episodes of behaviour that challenged or the actions they needed to take in respect of each person to reduce or minimize the risk of aggression.

The NICE Guidelines 'Dementia: Supporting people with dementia and their carers in health and social care' 2006 states: 'People with dementia who develop non-cognitive symptoms or behaviour that challenges should be offered a pharmacological intervention in the first instance only if they are severely distressed or there is an immediate risk of harm to the person or others. The assessment and care-planning approach, which includes behavioural management, should be followed as soon as possible'. Our observations and discussions with staff showed these guidelines were not being followed.

During the inspection we spent time with people in the communal lounge areas and dining rooms. We saw that some staff were attentive, showed compassion, were patient and interacted well with people. However other staff rarely spoke with people who used the service and limited their interactions to giving orders to people who used the service. We saw that when people became anxious some staff intervened in very supportive ways and used techniques such as distraction and going to quieter areas of the home. Whereas other staff did not appear to notice and ignored people.

This is a breach of regulation 17 (Respect and involving service users) of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

Some of people who used the service could become disinhibited and individual's needed staff to discreetly support them reduce this behaviour or minimise the impact on others. We found that the assessment and care plan documents for people who were noted by staff to display sexually inappropriate behaviour had not been updated to include detailed information that would guide staff practice and help reduce the impact or likelihood of the behaviour. They found that the care records did not provide information about the frequency, intensity or triggers for incidents nor did the records provide detailed guidance to staff around how to provide a therapeutic environment which could lead to less frequent incidents or how to deal with incidents if they actually occurred.

This is a breach of Regulation 9 (Care and welfare) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found some peoples' bedrooms had been personalised with their furniture, photographs treasured possessions and mementoes. However we found other bedrooms, particularly on the first floor 'male only unit' to have no personal possessions or no individual items at all. This did not demonstrate that peoples' previous lifestyles, significant experiences and personal history were known about and valued by staff.

We observed a lunchtime period and found people who needed support with eating were treated in a caring way. One member of staff talked to a person throughout their main course and told them what was on their spoon before giving it to them.

We did receive some positive feedback about staff from visitors and relatives. One service user told us, "Some of the

Inadequate

Is the service caring?

Carers are excellent." One relative said the care was 'good' and they were satisfied with the care given to their loved one. Another told us, "Staff have lovely attitude towards residents."

Inadequate

Is the service responsive?

Our findings

There was a lack of effective person centred care for people who had dementia type illness or nursing care needs.

We looked at care planning records which showed they were not sufficiently detailed to consistently guide staffs practice and were not updated in response to incidents or changes in service users' condition. We looked at the assessment or care plan documents for seven service users who were noted by staff to display challenging behaviour. We found these did not provide any guidance to staff around how to manage the challenge and deal with any episodes of aggression; and records had not been updated to show that staff had learned from incidents or revised their approaches as a consequence. One person who had been involved in a number of incidents had a care plan which stated, "Care plan and Risk assessments are to be continually evaluated." However there were no changes or additions to indicate the care plans and risk assessments had been since they were first written. Another person had a care plan which stated,

"Care plan to be evaluated monthly." However there were no changes or additions to the care plan for over three months. Another persons' risk assessment stated, "1:1 observation if appears verbally and physically aggressive may cause injury" However there were no evaluations, changes or additions recorded in the risk assessment for two over months.

We also saw that the assessment and care plan documents for service users who were noted by staff to display sexually inappropriate behaviour had not been regularly updated to include detailed information that would guide staff practice and help reduce the impact or likelihood of the behaviour. They found that the care records did not provide information about the frequency, intensity or triggers for incidents nor did the records provide detailed guidance to staff around how to provide a therapeutic environment which could lead to less frequent incidents.

We found there was a lack of person centred care for those people at the home who had skin pressure damage. When we asked the nurses on duty whether any of the service users had or were at risk of developing pressure ulcers they told us that no one in the home had a pressure ulcer. However from a review of the care records we found that four service users were being treated for actual pressure ulcers or the risk of developing them.

We also saw that the assessment and care plan documents for service users who were noted by nurses to have or be at risk of pressure damage were not regularly updated. For example one person had an "Open Wound Assessment Chart" dated 9 July 2014 which detailed that a service user had a pressure ulcer. However a care plan was not put in place until 3 September 2014 and had not been subject to a 'review in 3 weeks' as described in the 'Action Plan.' There was also a completed body map detailing a different area of skin damage but no additional or amendments had been made to the care plan.

This is a breach of Regulation 20 (Records) of the Health and Social Care 2008 (Regulated Activities) Regulations 2010.

We found that the service had failed to take proper steps to assess, plan and deliver care in such a way as to meet service user's individual nursing needs. For example we found conflicting information was contained in one person's records which indicated that they may have been suffering from several life limiting and serious illnesses. We found that none of the assessments or care plans reflected this information or what, if any implications this meant for their health and wellbeing. None of the staff we spoke with could outline this person's current condition, prognosis or impact on how they delivered care.

We found there was a lack of person centred care for those people at the home who displayed sexually disinhibited behaviour. For example we saw one person's care plan which stated, "can exhibit sexualised behaviour." However there was no further information or explanation in the care plan of what were likely stimulus or triggers to this persons behaviour nor was there step by step guidance to inform staff about what they should do to support the person in a positive way to help avoid this behaviour or what to do when he exhibited this behaviour. There was no acknowledgement in the care plan that this behaviour was due to this person's dementia nor did the care plan acknowledge their individual needs, background, life history and circumstances.

We also saw that the assessment and care plan documents for service users who were noted by nurses to have or be at

Inadequate

Is the service responsive?

risk of malnutrition were not accurate, complete or regularly updated. For example one person's care plan we looked at said, '(Service user name) requires prompts and close supervision from staff when eating and drinking." which indicated that they had nutritional needs. However this care plan did not note, consider or instruct staff to monitor this person's diet in relation to other medical conditions. Food and fluid balance charts which were also specified in the care plan could were not be found to be in place and there was no reference to their use in determining the effectiveness of nutritional or nursing care strategies.

This is a breach of Regulation 9 (Care and welfare) of the Health and Social Care 2008 (Regulated Activities) Regulations 2010.

We looked at how complaints were handled at the home and found the provider had a 'Complaints Policy'. The policy stated, "All complaints are responded to in writing by the home". We spoke with one relative who had made a complaint in May 2014 to the provider. The relative told us the provider asked if they wanted the complaint to be put in writing and they had said "Yes." However when we looked in the complaints file we found the written complaint did not have a response.

This is a breach of Regulation 19 (Complaints) of the Health and Social Care Act 2008 Registration Regulations 2009

We found that no therapeutic activities took place which would provide interest or stimulation and help promote positive behaviour and improve service users' wellbeing. We saw staff responded to service users' requests if they were awake, however, there were no proactive interventions from staff. We observed that if service users were asleep care staff left them to sleep. Staff could not identify reasonable reasons why service users were so sedate. We found that the service failed to take reasonable steps to ensure staff adopted published research evidence and guidance issued around the treatment of service users with dementia such as the NICE publication 'Dementia Supporting service users with dementia and their carers' in health and social care 2006' which included advice about how the service should respond to people with dementia.

This is a breach of Regulation 17 (Respecting and involving service users) of the Health and Social Care 2008 (Regulated Activities) Regulations 2010.

The provider was also unable to respond when changes took place at the home. For example one

relative told us that their loved one got a new bed but the home did not have the sheets to fit on

their bed. The relative subsequently purchased them and brought them into the home.

Inadequate

Is the service well-led?

Our findings

The home was not well run, operational procedures were disorganised and oversight by the provider was ineffective.

We found that there was not a registered manager in post at the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We found the area manager and acting home manager had both only recently been appointed in post approximately five weeks prior to our inspection. We looked at CQC records which showed that the previous registered manager left the home on 30 September 2013 and CQC had not received any applications for the registration of a manager since that date.

This is a breach of the condition to have a registered manager (Regulation 5), of the Health and Social Care Act 2008 Registration Regulations 2009

We looked at how the provider assessed and monitored the quality of the home to make sure it was safe, effective and meeting the Statement of Purpose. We saw the provider had a file named 'Quality Assurance Policy.' The policy stated, 'The home must protect residents, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment,' and this was to be done via the 'effective operation or systems.' The policy stated that Gainford Care Homes have in place, amongst other systems to, 'Identify, assess and manage risks relating to health, welfare and safety of residents and others who may be at risk'. However the acting manager and the regional manager told us they could find "nothing in place."

In the same Quality Assurance Policy we saw the provider should have an annual plan to ensure a quality service; residents and relatives surveys were to be carried out on a three monthly basis and professional surveys were to be carried out every six months. However we were unable to find any evidence of these surveys being carried out, the acting manager and area manager told us they had not found anything either and had been unable to implement any surveys in the five weeks they had been working for the provider.

Following the inspection in July 2014 CQC had asked that the provider regularly monitor the ambient temperature throughout the home and take action should this become excessive. During this inspection we found the ambient temperature of the home to be again in excess of 26°c. Inspectors asked to see the temperature monitoring records and were told by the maintenance personnel that none had been produced. The acting manager told us they were unaware that the CQC had required this action to be taken or that remedial action was required to ensure the ambient temperature of the home remained in line within Health and Safety guidelines.

We asked the acting manager and the administration staff for evidence around how the service was monitored or overseen by the provider including any visits that had been completed in the last six months. Staff were unable to produce this information and the acting manager confirmed that they could not find any such documents and was not aware that any had been produced. We found that the provider failed to assess and monitor the quality of the services provided at the home.

We found that the provider failed to make improvements to the quality and safety of services for people at the home. The provider did not take action following a CQC inspection of 9, 10, 22, 24, 29, 30 July and 7 August 2014 where the home was found to be in breach of five regulations and people using the service were found to be at risk despite Warning Notices being issued. The provider did not act in a timely fashion to achieve compliance, meet service users' needs and adequately protect them from receiving poor care. Although the provider had taken steps to appoint an acting manager and area manager, approximately five weeks before this inspection, their impact on the service remained inadequate and we found the provider remained in breach of regulations which warranted further enforcement action to be considered.

This is a breach of Regulation 10 (Assessing and monitoring the service), of the Health and Social Care Act 2008 Registration Regulations 2009

We found the provider did not adequately check the quality of staff who worked at the home. For example we found that no checks had been made to confirm recently employed nurses were registered with the Nursing and Midwifery Council (NMC). The acting manager confirmed that no checks were made to ensure that existing nurses employed at the home remained registered had the

Inadequate

Is the service well-led?

competencies to meet the needs of the service users or to check that they remained competent and had completed continuous professional development training. We asked the acting manager and the administration staff for evidence around how the provider monitored staff training needs and their attendance at courses. The acting manager confirmed that staff training files were not in an organised condition where they could be used to identify staffs present training needs or their previously completed training.

This is a breach of Regulation 21 (Requirements relating to workers) of the Health and Social Care Act 2008 Registration Regulations 2009

We found that neither acting manager, area manager nor the deputy manager, had been made aware of recent safeguarding incidents and had failed to identify, assess and manage risks relating to the health, welfare and safety of service users. We asked acting manager and the administration staff for evidence of the outcome of safeguarding investigations or the rationale for actions taken such as separating service users by locking the entry doors of the first floor male only unit. We also asked for evidence of the monitoring arrangements that the home used to determine that actions identified as needing to be put in place following a safeguarding investigation by the Local Authority Safeguarding Adults Unit, were actually taken. Staff were unable to produce this information. The acting manager confirmed that they could not find any such documents and was not aware that any had been produced.

This is a breach of Regulation 20 (Records) of the Health and Social Care Act 2008 Registration Regulations 2009

One relative commented on the changes made by the new acting manager and said, “Having a senior carer downstairs means there is better leadership and direction.”