Care Quality Commission

Stephen Oldale and Susan Leigh

Lockermarsh Residential Home

Inspection report

36 Ellison street
Thorne
Doncaster
South Yorkshire
DN8 5LH
Tel: 01405 740777

Date of inspection visit: 27 October & 2 November 2015
Date of publication: 13/01/2016

Ratings

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

Overall summary

This inspection took place on 27 October and 2 November 2105 and was unannounced on the first day. The home was previously inspected in December 2014 when we found breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) 2010. Following that inspection the registered manager sent us an action plan to tell us what improvements they were going to make. They told us the improvements would be completed by the end of September 2015.

Lockermarsh Residential Home is a care home providing accommodation for older people who require personal care. It also accommodates people who have a diagnosis of dementia. It can accommodate up to 24 people over two floors. The floors are accessed by a passenger lift. The service is situated in Thorne north of Doncaster. At the time of our inspection there were 16 people living in the home.

Summary of findings

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left in August 2015. The provider had appointed a new manager who had commenced in post on 28 September 2015. They had only been in post four weeks at the time of our inspection. They had however, commenced the process to register with the CQC.

During this inspection we looked to see if improvements had been made since our last inspection in December 2014. We found improvements although implemented had not been sustained.

We identified further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people had care and support plans in place, however, care records did not always fully reflect the care they required. The plans had not been reviewed or updated when people's needs had changed. People's risk assessments had also not been reviewed or updated to ensure their safety.

People were not always protected against the risk of abuse. The provider had not always followed clear safeguarding policies and procedures. Staff we spoke with were aware of procedures to follow but did not fully understand whistleblowing procedures.

There were not always enough staff to meet people's needs. People who lived at the home and relatives told us they did not think there was enough staff on duty to meet their needs. We also found there was lack of activities and stimulation during the day. People told us there was not much to do during their day as staff were busy.

Staff were recruited safely, however it was not clear if staff had received an induction and we found training and supervision was out of date.

Infection prevention and control had improved. However, due to changes in the management structure since our last visit there was a decline in monitoring the environment and implementing infection control measures.

People were protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines.

The new manager understood the legal requirements of the Mental Capacity Act (2005) Code of Practice. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. However, care staff we spoke with were not always knowledgeable about this legislation and how it impacted on people they supported.

A well balanced diet that met people's nutritional needs was provided. However, we found people were not supported to be able to eat and drink sufficient to ensure they received adequate nutrition. People had lost weight and no action had been taken.

Staff told us they felt supported by the new manager. They said they felt confident that they could raise any concerns with the manager and felt that they were listened to. Relatives told us they were happy to raise any concerns directly with the manager.

We found the systems in place to monitor and improve the quality of the service were ineffective. The operations manager and the provider told us that they visited the home once or twice a month to monitor quality. We saw the reports did not clearly detail what action was required, who was responsible for implementing it or any timescales for completion. We also saw the audits did not cover all aspects of the service provision.

We found seven breaches of The Health and social care Act 2008 (Regulated Activities) Regulations 2014. We are taking action against the provider, and will report on this at a later date.

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.

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.

Staff could tell us how to recognise and respond to abuse. However we found people were not protected as the provider had not followed procedures to safeguard people.

Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines.

There was not always enough staff to provide people with individual support required to meet their needs.

Infection prevention and control measures had improved. However, due to changes in the management structure there was a decline in monitoring the environment and implementing infection control measures.

Is the service effective?

Inadequate

The service was not effective.

Staff were recruited safely however staff did not receive adequate supervision, as required by the provider's policy.

Although people's needs had been assessed and care plans were in place we found these had not been reviewed or updated and were not followed by staff.

Mental Capacity assessments had taken place in line with legislation and the new manager had a good understanding. However care staff were not clear when questioned on how this impacted on people they supported. We did not see evidence of best interest decisions being made where people lacked capacity.

A well balanced diet was provided. However the meal times we observed were disorganised and we found people were not always given choices and staff did not interact with people to ensure the meal service was a positive experience. Therefore people were not supported to ensure they received adequate nutrition and hydration.

Is the service caring?

Requires improvement

The service was not always caring

We did not see any interactions that were not kindly. However, there was very little positive or social interaction from staff with people who used the service. We did not see that people were supported to be able to express their views or involved in making decisions.

Summary of findings

Some people and their relatives told us they were not always happy with the care provided. This was mostly regarding lack of stimulation and activities leading to isolation.

Is the service responsive?

Inadequate

The service was not responsive

We saw people had health, care and support plans. However, we found the support plans, were not reviewed or updated and did not reflect people's changing needs. This meant staff were not always aware of people's needs and how to meet them.

We found care plans did not always reflect people's choices, wishes or decisions and did not show involvement of the person. It was clear from observations that staff did not always give people choices or wait for them to make decisions.

Is the service well-led?

Inadequate

The service was not well-led.

There was not a registered manager in post.

People were put at risk because systems for monitoring quality were not effective.

Monitoring of accidents and incidents was not effective, it had not been completed since July 2015 and had not identified any issues that needed to be resolved.

Staff told us the new manager was approachable and did listen to them.

Lockermarsh Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 27 October and 2 November 2015 and was unannounced on the first day The inspection team was made up of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The local authority contracts officer and an infection, prevention and control nurse specialist were also present during our inspection.

Before our inspection we reviewed all the information we held about the service. We spoke with the local authority, commissioners, safeguarding teams and Doncaster Clinical Commissioning Group. The local authority officer told us they had concerns regarding the service. These were regarding lack of management and staffing levels. Although they had seen improvements in infection control.

We spent some time observing care in the dining room to help us understand the experience of people who used the service. We looked at all other areas of the home including some people's bedrooms, communal bathrooms and lounge areas. We looked at documents and records that related to people's care. We looked at three people's support plans. We spoke with five people who used the service and five relatives.

During our inspection we also spoke with eight members of staff, including care staff, deputy managers, the acting manager and the operations manager. The provider was also present on the first day of our inspection. We also looked at records relating to staff, medicines management and the management of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection in December 2014 the service was in breach of regulation 13 HSCA 2008 (regulated activities) regulations 2010, management of medicines. Management of medicines had improved and we found medicines were stored and administered safely. People received medication as prescribed

People told us that medication on an individual level was handled well. One person told us, "I take medication, I don't know what it is, they give us them, get them from the doctors." We saw a deputy manager giving out medication from a trolley. We saw her take medication to a person in the lounge and that while she did this she left the medication trolley locked with all medication inside it. We saw that she gave the medication to the person in the lounge in a kindly, reassuring manner, explaining what it was and remaining with that person until she was sure all medication had been taken.

The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with were knowledgeable on procedures to follow. However not all staff were knowledgeable on the whistleblowing procedures. Staff could tell us how to recognise and respond to abuse. However we found people were not protected as the provider had not followed procedures to safeguard people. For example we looked at how the service responded to investigating safeguarding incidents, we found in one incident no safeguards had been put in place to protect people who used the service whilst an investigation was on-going. We also identified another safeguarding incident that the actions planned to safeguard people following the investigation, had not been carried out putting people at risk of abuse and improper treatment.

During our inspection we also identified four potential safeguarding incidents; this was regarding care plans not being followed putting people at risk of neglect. Following discussion with the manager they did refer these to the local authority safeguarding team at the time of our inspection.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With regard to the number of staff on duty, most people who used the service and relatives we spoke with said there were not enough staff on duty to meet people's needs. Most people we spoke with told us there was nothing to do. One person when asked what she did all day told us "Just sit around and watch telly, we get bored really but there's nothing we can do."

The acting manager showed us the staff duty rotas and explained how staff were allocated on each shift. Staffing levels were not determined by dependency levels of people who used the service. We saw that there were usually three staff on days and two on nights. The manager told us this was the levels they tried to maintain, however sometimes due to sickness they would have to find cover and this meant they may be short while they were waiting for a staff member to travel to work once they had been contacted. We were told by the manager and staff they were not able to use agency staff as the provider did not authorise this. When we arrived at the service on the first day of our inspection there were only two staff on duty. Staff told us some people who used the service required two staff for some areas of support. We saw one staff member was administering medication and another was in people's rooms assisting with personal hygiene. This meant there were no staff present in communal areas where five people were sat in the lounge and three in the dining room. We saw the cook was bringing in peoples breakfast but no staff were available to give assistance to people with eating.

The deputy manage told us that one care worker had called in sick so they were waiting for another care worker to arrive who was covering. A third care worker did arrive later.

The expert by experience spent time observing in communal areas and observed people were left without staff supervision for considerable lengths of time during the day.

When we looked at records it was clear a number of people did not sleep during the night and presented with behaviours that could challenge. Staff told us this was difficult to manage with only two staff as they also had to do the washing and cleaning during the night. This meant there were not enough staff on night duty to meet people's needs.

We also found there was lack of activities and stimulation during the day. People told us there was not much to do during their day as staff were busy. Although we saw staff sitting around chatting to each other they did not engage

Is the service safe?

with people who used the service. We saw one deputy sat chatting with the other deputy who had come in for a coffee and was not on duty. Staff also sat in the lounge completing care records and did not engage with people.

The acting manager and operations manager told us that they were extremely short staffed as a number had left. There were two deputy managers, three full time care workers, two part time care workers and three bank staff. On the second day of our inspection we found four care staff and the domestic were on leave this had left the service extremely short staffed. However, one care worker agreed to work as they were not away. The acting manager explained this would not normally be approved but the previous manager had approved this and so it had to be honoured. Other staff had picked up additional shifts to ensure they were covered. This left very little flexibility if sickness occurred. The number of staff and deployment of staff did not ensure people's needs were always met.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at recruitment procedures. We found mostly the required employment checks were undertaken. The acting manager told us that staff did not commence work with people who used the service until references had been received and they had obtained clearance to work from the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We looked at the recruitment files of five staff and spoke with staff that were on duty on the day of this inspection. Information within the recruitment files confirmed that the required checks had been carried out prior to commencement of employment at the service. However we found one file did not contain the required checks; there was no application form and no references. The person had been in post a year. We discussed this with the acting manager who agreed to look into it.

Before our inspection, we asked the local authority commissioners for their opinion of the service. The local authority officer told us they had concerns regarding the service. These were regarding staffing, management and meeting people's needs. The officer told us they had seen improvements particularly in medicine management and infection control. They said they were continuing to monitor the service. However, they said they were more confident as the new manager was aware of what was required to improve the service.

We looked at the cleanliness of the environment as part of our inspection, we found in general this had improved, predominantly the environment and equipment was found in a clean condition.

On the second day of our inspection an Infection prevention and control (IPC) nurse specialist visited the service. They carried out an audit following a quality tool. This is an adapted nationally recognised tool and is following up to date current guidance. The nurse specialist had visited previously as we had had concerns. They found there had been further improvements in line with the action plan the service had provided at their last visit. This was in regard to refurbishment of the home. Several bath chairs and floorings had been replaced. The home was visibly clean including individual and communal client equipment. Damaged furniture has been removed and condemned.

The home has identified a decommissioned toilet (downstairs) that is going to be refurbished into a domestic room to ensure there are separate facilities for domestics to prevent risk of cross contamination. At our previous inspection we found domestics were utilising bathrooms.

We did note there was a malodour in the corridor near rooms 1 and 1A. Documentation including policies and procedures and cleaning schedules were not available. The service had also not identified an IPC lead.

The IPC nurse specialist had concluded in their report, the home has made considerable improvements in regards to refurbishment of key areas since the previous visit to the home. However, due to changes in the management structure since our last visit there was a decline in monitoring the environment and implementing IPC measures that were previously advised. The new management team have stated that they have not had access to the information, reports or guidance that was previously sent. The overall rating of the audit remained in red, but this was due to lack of management and auditing of practice.

Inadequate

Is the service effective?

Our findings

At our last inspection December 2014 we found a breach of regulation 18 HSCA 2008 (regulated activities) regulations 2010. People did not receive care or treatment in accordance with their best interests. The Mental Capacity Act 2005 was not always followed.

At this visit we found some improvements had been made in relation to ensuring the requirements of the Mental Capacity Act were followed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). The new manager had assessed people who used the service in line with the guidance. Applications for some people for a Deprivation of Liberty Safeguards (DoLS) had been sent. This was to ensure the requirements of the regulation were met. DoLS requires providers to submit applications to a 'Supervisory Body' for authority to do so. As Lockermarsh Residential Home is registered as a care home, CQC is required by law to monitor the operation of the DoLS, and to report on what we find. However, when we spoke with care staff we found they were not always knowledgeable about mental capacity and how this impacted on the people they supported. Therefore staff who were providing care and support which required consent were not able to apply the codes of practice associated with the act.

We also found best interest decisions were not always made or recorded in people's plans of care. We identified in one persons plan that inappropriate continence wear was being used. We discussed this with the manager who told us the person lacked capacity to make the decision to wear continence pads. It was therefore necessary to look at the best interests of the person to decide what was required to be used to ensure their needs were met. There was also no best interest decisions regarding doors being locked and no access to the outside for people who lacked capacity to consent.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they had received training that had helped them to understand their role and responsibilities. However what we observed did not always reflect this and it was not clear if the training had been effective. When we spoke with the deputy managers they told us training was out of date and all training was required again. The services was in the process of contracting the services of a new training provider and had a meeting arranged for 20 November 2015.

The deputy told us that some training had been updated which included moving and handling, fire safety and safeguarding. However other training for example infection control, managing challenging behaviour, health and safety, end of life and food hygiene were out of date and required to be updated to ensure staff had the necessary skills and knowledge to safely carry out their role.

We looked at training records which we were told was devised by the previous manager and this showed most training was out of date. The record was out of date as staff names on the record did not tally with staff who were currently working at the service. We also looked at training certificates in files and these were also out of date. It was not clear from records seen when staff had completed training or if training was due.

Staff told us they had completed an induction when they commenced employment. When we looked at the training record this did not reflect what staff told us. The record showed only seven staff had completed induction. Staff also told us they had received formal supervision although these were not as frequently as they would like. Staff however, acknowledged that the new manager was supportive and felt the service was in a better place now the new manager was in post. Staff had received annual appraisals however; these were not up to date. The acting manager was aware of this and knew they had to be arranged. This meant staff had not had effective induction, supervision or appraisals.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

We spent time in the dining room during lunch. We observed the food service and staff support. We found people were not always given choices and staff did not interact with people to ensure the meal service was a positive experience. When we looked at the picture menus displayed in the dining room for people to see we saw this had not been followed on the day of our inspection. The meal shown on the board was not served. There was a chalk board outside the dining room which had the meals written, however people who used the service were living with dementia so would find it easier to see picture menu choices. The lack of correct meals displayed meant people would not understand what the choices were.

We saw that some meals were simply placed in front of people with little interaction. We did see one care worker say, "(name) corn beef hash." And, "(name), corn beef hash." When putting meals in front of two people, there was no other explanation or checking if indeed that was what that person expected or wanted.

We did see one member of staff give a meal to a person who appeared to have a visual impairment. We saw that the care worker told them what the meal was, that it was "in front" of them then gave them a knife and fork. However the staff member left them quickly without checking that they had processed this. The staff member did not ask if they would like salt and pepper. We had observed this person at breakfast and we saw them trying to find the salt and pepper and we had to ask a staff member to assist them.

We saw a member of staff sit down at the end of a table and help one person with their meal but they did this by using a spoon to move food around on the plate. They did not talk to the person while they were doing this. The staff member did however talk to colleagues in the room whilst they were supporting this person with their meal.

We saw one person who was sitting at a table hold up their beaker and ask a care worker for a drink of water. The care worker said "I'm bringing a jug of juice in a moment." Then left the room. The care worker did not get that person a drink of water. We saw later that the care worker came back into the room to get a protective apron and in passing say to that person "Getting your juice now (name) love." She then again left the room.

Five minutes later we saw the care worker bring jugs of juice into the dining room and proceed to pour juice into people's beakers saying as she did this, "Do you want some juice." We saw that the care worker did not actually wait for responses to the question neither were people offered any alternative flavours of juice or drinks of water.

We saw a care worker bring a plated meal to a person sitting in the lounge and say to that person "Put this on and I'll feed you your dinner." We saw the care worker put an apron on that person and then sit next to them and start 'feeding' the person. We observed little interaction between the staff member and the person with the support worker sitting alongside the person, effectively out of their line of vision and then simply staring out of the window while they waited for the person to finish each mouthful. This meant people who used the service were not supported to ensure they received adequate nutrition and hydration. This was also evidenced through care records we looked at as we saw people's weights were not being regularly monitored and some people had lost weight without any action being taken.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw in people's care files that risks had been identified and measures in place to manage the risks. However when we looked at management of the risk to people of not receiving adequate nutritionwe identified that people had lost weight. The risk assessments instructed that they should be weighed weekly and if they continued to lose weight they should be referred to a dietician. People who used the service had not been weighed for a few weeks; we were told this was because they had not had any working scales. People who had lost weight had not been weighed since August 2015. Most people had been reweighed in October 2015. We found one person who had previously been referred to a dietician for considerable weight loss had again lost weight from August to October 2015; they had lost a further 0.9kgs. We found no evidence their care plan or risk assessments had been reviewed since June 2015. They had been assessed at risk of poor nutritional intake but had not been evaluated in four months. This meant their changing needs and risks to their helath and wellbeing were not being monitored or addressed. We also found that people who had been assessed as at risk of weight loss, had not been placed on a food and fluid chart to monitor food intake as the risk assessment stated.

Inadequate

Is the service effective?

We looked at food and fluid charts that had been completed. We found these were not completed fully or evaluated to determine if the person had eaten adequate nutrition.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The previous registered manager had taken into consideration the environment for people living with dementia and had commenced improvements on the first floor to ensure it was conducive for people living with dementia. For example, the walls had been painted different colours to bedroom doors and bathrooms so people were able to differentiate between them. However the communal areas downstairs did not meet the needs of people living with dementia. These were the areas that people spent most of their time. The floor coverings were highly patterned and the walls were plain. One visiting relative commented on the carpet, they told us in regard to their family member, "(my relative) wouldn't go in the small lounge, he thought he was walking on (sea)shells." We also found the light levels in a number of toilets and corridors were very dim and required better lighting to ensure people were able to see clearly in these areas.

There was no visual stimulation, the prints on corridor and room walls were of a type and colour which merged into the walls and offered little stimulation.

There was little attempt at providing memorabilia or reminiscence material. There were some scarves on racks and an old photo of police officers but little else that people could identify with or would offer subjects for interaction with people.

There was a large antique effect clock in the lounge but this had very small hands and the distressed face meant it could be confusing and difficult to read, particularly for anyone with any dementia or vision problems. There was a second clock in the lounge but this was small and again difficult to read. We discussed the environment with the new manager who was aware some areas were not dementia friendly and required improvements.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People we spoke with told us they felt staff were caring. One person said the service was, "Like home from home, I've my own bedroom and that, I've no faults with any of it." They added, "Staff are very nice, I've no complaints". Another person said staff were, "Good."

One person told us in regard to one member of staff, "She's nice to talk to."

One visiting relative told us "I've no problems with the care, (my relative) came for respite and I didn't like that, but they have stopped, they really like it. I feel comfortable that they are here. They are well fed, get some nice food."

However, whilst we did not see any interaction that was not kindly a significant concern would be that there was very little positive social interaction. The main concern would be that most care seen was neutral in that staff comments were directed to everyone. Often in passing, but individual responses were not really invited or responded to. We observed this behaviour from all levels of staff in the organisation, with the exception of the new Manager. A great deal, indeed the majority, of interactions were task orientated and much was delivered from a "distance".

We saw few examples of people being offered encouragement or of opportunities being taken by staff to engage with people. It was not felt that this was because staff were too busy as we saw that staff spent a great deal of time talking to each other or simply standing or sitting around. For example, in the morning we saw two staff sitting down at a dining table chatting socially, one member of staff was not on duty but told us, "We call in for a coffee."

We also saw a care worker sitting on her own at a dining table. They were not doing anything and there was no-one else in the dining area at that time.

We also observed a care worker leaning on a wall in the dining room. We saw they shouted across the dining room to a person seated at a table, "What's up (name)." But the member of staff did not approach that person. We saw that carers often sat down next to people but there was not always any interaction.

We saw a care worker sitting at the same table as person who used the service who was having porridge. The care worker sat some distance from the person and asked if the person liked the porridge. The care worker gave no encouragement to the person and no assistance was offered or given. The staff member left. A few minutes later another care worker came into the dining room, said to the person, "Have you finished it." and simply took the plate away. Again, whilst this was not said in an unkind manner no encouragement to eat was given and no assistance offered or given.

We saw three people sitting on seats in the foyer area. We saw staff constantly pass these people and whilst most enquired if the people were, "alright" none stopped to actively engage with them.

We also observed a member of staff come into the lounge, say generally to people, "You like this don't you." We assumed they were referring to the television programme. They then sat on a window ledge and looked out of the window. There was no other interaction with people present.

No one we spoke with told us they were aware of or had been involved in care planning. One person when asked about care plans said, "I've no idea." Asked if they had had a meeting to discuss their care they said, "No, nothing." A visiting relative who told us they had not been involved in any care planning for her family member.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some examples of good positive social care. We saw a deputy manager talk to one person, enquiring how she was. We saw the deputy knelt down so she was at eye level with the person and reassuring her with appropriate touching. We also saw the manager come into the lounge and speak generally to people. She then engaged with one person, asked them how they were and waited for a response. The manager then sat down and spoke to that person for several minutes before leaving.

Inadequate

Is the service responsive?

Our findings

At our previous inspection in December 2014 the service was in breach of regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People's documented care records did not reflect their current needs that were being delivered by staff.

At this visit we found care plans mostly reflected people's needs and how to be able to meet people's needs. However, we found these were not always followed, reviewed or evaluated. This put people at risk of receiving care and support that did not meet their needs.

We looked at four people's plans of care and found each person's care plan outlined areas where they needed support and gave instructions of how to support the person. However, these were not reviewed or evaluated. In some instances from evidence and observations we found staff did not always follow care plans. For example one person's care plan stated they could at times present with behaviour that may challenge. There were monitoring charts in place to be completed. We saw the charts had been completed in July and August and incidents had occurred. The care plan or risk assessment had not been reviewed since June 2015 and we found no further monitoring records completed. When we spoke with staff they told us at times the person could still present with challenging behaviour. Therefore the care plan had not been followed to ensure the persons safety. Lack of monitoring or review meant any triggers or themes to the persons behaviour could not be identified or eliminated.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection relatives told us there were not always enough activities or stimulation provided for people. Relatives said they, (the people) mostly watched television. At this inspection we found the same and relatives were still telling us there was little or no stimulation.

We found the main lounge was arranged with seating around the perimeter of the room with one wall being dominated by a large television which, when we first arrived had on children's television. This was not appropriate for people who used the service. We found the television was on for most of the time we were on site. Whilst we did see two sessions of group activity taking place during our inspection, we saw that people were mostly left simply sitting in chairs in the lounge, dining area foyer area or small television room with nothing to do and no staff presence for a significant amount of the time.

In the morning we saw a member of staff getting out a large floor based Snakes and Ladders game. It was obvious that this was a new, unused game. We saw that the staff member did this in a friendly, kindly manner. However, although the carer had a generally good rapport with, and showed good knowledge of people, she did not appear able to engage people or explain what was expected of them and therefore the exercise was not inclusive.

When returning to the lounge 55 minutes later we saw that all activity had stopped and equipment had been cleared away. The same seven people were again sitting around the perimeter of the room and the television was on again.

In the afternoon we saw a member of staff playing skittles with ten people in the lounge. However this only lasted half an hour. Then again the people sitting in the lounge were again doing nothing. The television was on but not many people seemed to be watching it. There were no staff present.

People who used the service told us there was lack of stimulating activities. One person when asked what she did all day told us, "Just sit around and watch telly, we get bored really but there's nothing we can do. We have our meals at proper times." She then added though "Sometimes we have games, we did yesterday." Another person said, "Nothing really, not a lot, you can get bored." And another person, when asked what they did all day tapped their chair indicating they just sat all day, then said, "And the toilet."

A visitor told us, "They need to be doing a lot more. We came in the other day and the telly was blaring away and they were all sat around the edge, that's not right, they need to be sitting in groups so they can talk. (My friend) sings but everyone has got their own little thing; if there was a little bit more interaction instead of just the telly it would be good for them all. (My friend) just sat there on the side, no communication, no nothing; I don't think it's right. There's all that floor space they could push people together more."

Staff members also told us there was lack of activities. One told us, "We've been asking for an activity co-ordinator for a long time – it was up to us and we were struggling,"

Inadequate

Is the service responsive?

We looked at people's care files to see if they were individualised and personalised. We found they did not always reflect people's choices, wishes or decisions and did not show involvement of the person. It was clear from observations that staff did not always give people choices or wait for them to make decisions.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a comprehensive complaints' policy, this was explained to everyone who received a service. This was displayed in the entrance area. During our inspection one relative raised a concern, we asked the manager to look into their concerns. At our second visit we found the manager had investigated the concerns and ensured they were addressed. The manager had recorded the concerns and action taken with conclusion in line with the complaints policy. No one else raised any concerns with us, but said if they needed to raise anything they would speak with the manager or the deputies.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the service did not have a registered manager. The registered manager had left in August 2015. A new manager had been appointed and commenced in post on 28 September 2015. Therefore at the time of our inspection had only been in post four weeks. When we spoke with the manager when they arrived at the service. They told us in the four weeks they had been in post they had identified that the service required a lot of improvement. They had identified shortfalls and were in the process of devising an action plan to ensure all areas requiring improvement would be addressed.

At our previous inspection in July 2014 and December 2015 we found a breach of regulation 10 HSCA 2008 (regulated activities) regulations 2010. Regarding assessing and monitoring the quality of service provision. This corresponds to regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

At this visit we found systems that had been put in place had not always been followed and quality monitoring and audits had lapsed. For example we looked at incidents and accident monitoring we found these had not been completed since July 2015. The new manager told us they had been devising new audits to ensure quality monitoring could be implemented.

We also found ineffective monitoring of staffing, failure to monitor staffing levels to ensure sufficient staff on duty and failing to monitor practice to ensure adequate staff were deployed to meet people's needs. We identified poor care record completion and weight loss, which had not been identified through effective quality monitoring or audits. The issues we found at this inspection and detailed within this report had not been identified through an effective monitoring system.

We found the managers monthly audit that we were told was carried out by the operations manager. This was dated 7 October 2015. The report was not completed and mainly looked at the environment. The report stated the home was odour free, yet we identified a strong odour in some areas. It also did not identify that only one bathroom was in working order or that the lighting in a number of toilets and corridors was very dim and needed better lighting. The audit just stated all in working order. Staff we spoke with were very frustrated regarding the lack showers or a wet room they told this had been raised many times with the previous manager and provider. Staff told us, "I raised this continually with management." This was still unresolved.

The audit covered incident records and risk assessment but these sections were blank so had not identified these had not been carried out. It did identify the training matrix required updating as soon as possible and that care plans were to be rewritten, however, there was no action plan, detailing who was responsible for the action and no timescales for completion. The training matrix was not updated at our visit on 2 November 2015 which was nearly four weeks after the audit. The audit was therefore not effective in ensuring standards were improved and sustained.

The audit also had a section to record findings when staff were spoken with. This section was blank. The subjects to discuss with staff included safeguarding and whistleblowing. When we spoke with staff they told us they had received training on whistleblowing, although they said, "Only a small amount." Those spoken to however could describe what they would do if they had concerns about the management. This had not been identified as part of the quality monitoring.

We also saw two provider audits dated 10 July 2015 and 23 September 2015. These were hand written and were room checks. It identified areas that required attention but no action plan was attached. On both audits there were issues with the laundry; however no actions had been compiled following audit. This meant the audit was not effective.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt supported by management. One staff member told us "I do now, (current manager) is a much better manager, you can talk to her in confidence, she doesn't rely on us to do her jobs, which took us away from our main caring role."

People told us the manager was approachable. A visiting relative told us, "(current manger) is very approachable, I quite like her. She is very thorough and really approachable. I see how she works with the residents and she's really good, doesn't just stay in her office. She always asks how I am too."

Inadequate

Is the service well-led?

Staff told us the manager was approachable and did listen to them. One said if they went to the manager with any issues, "I'd definitely be listened to." Another told us she felt staff were, "listened to by the manager"

Staff told us that they had supervision with the manager or deputy but this to date had not taken place regularly. Some told us they thought this would change now with the new manager in post. One member of staff told us, "I've just had one (supervision session) but it's not regular. I constantly talk to the manager though."

Staff told us that they had staff meetings but again these had not been regular. One member of staff told us in regard to these meetings, "Previously it was hit and miss but the new manager is setting up one a month. We've had one already." Another said, "it varies. We'll probably get more now with the new manger."

Satisfaction surveys were undertaken to obtain people's views on the service and the support they received. We saw they had been sent out the in March and July 2015, four relatives had responded and two people who used the service had also completed a questionnaire. The responses had been mostly positive. The new manager told us they were looking at sending them out again to ascertain people's views on where the service was now to incorporate into their action plan.