Care Quality Commission

Ranc Care Homes Limited

Orchard House

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 2 and 5 October 2015 and was unannounced.

Orchard House is a care home which provides nursing and personal care for up to 67 older people, people living with dementia and people with mental health difficulties. People are accommodated on two units. Rivendell Unit is situated on the ground floor and accommodates people with nursing needs and Lothorian Unit, located on the first floor accommodates people living with dementia or mental health difficulties. There were 62 people living in the home at the time of this inspection.

There was a registered manager in post. 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.

Summary of findings

People were not always kept safe in the home. Although staff had been trained to recognise when people had been harmed, we found that they had not always informed the appropriate authorities of incidents when they should have done.

Risks to people's safety had not always identified, assessed and managed appropriately. Staff did not reassess or learn from any events that occurred in the service to improve their practice and keep people safe.

People's capacity under the Mental Capacity Act 2005 (MCA) had not been assessed to ensure decisions that were taken were in their best interests. People were at risk of being unlawfully detained as referrals to the appropriate authorities had not been made.

People were supported to take their medicines as prescribed. People who were not able to consent to taking their prescribed medicines did not have best interest decisions in place as no assessment under the MCA 2005 had been made. Therefore nurses were administering medicines outside of the current legislation. Audits of medicines had not been fully completed.

Staff did not treat people in a way that provided a positive experience for them. They did not promote individual care that focused on the needs of each person; instead they concentrated on just the task in hand. Activities for people to take part in were limited. People were provided with food that looked unappetising and pre plated. This meant people were not given any choice about their meal, such as vegetables or portion size.

People could not be sure that staff were competent to meet their needs because although staff had completed training they did not always demonstrate good practice during the inspection.

The home was not well managed. The registered manager had not recognised and identified where the home was failing and as such improvements had not been made where necessary. There was not a robust system in place to audit of the quality and safety of the home and lessen the risks.

People could not be assured that the culture of the home was open and transparent.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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.

People were not always protected from harm because there was a poor understanding of what might constitute harm and what procedure staff should follow.

Risks to people's safety and welfare were not robustly assessed and managed.

The recruitment process ensured that only suitable staff were employed to work with people living in the home.

Inadequate

Is the service effective?
The service was not effective.

People's capacity under the Mental Capacity Act 2005 had not been assessed to ensure decisions that were taken were in their best interest. People may be unlawfully detained as referrals to the required authorities had not been completed appropriately.

The food was unappetising and pre plated so that people did not have a choice of meal.

Communication between staff and people living in the home was limited and staff did not always demonstrate good practice.

Inadequate

Is the service caring?
The service was not caring.

Day to day practices within the home compromised people's privacy, dignity and independence.

Staff provided task focused care with few meaningful interactions with people.

Inadequate

Is the service responsive?
The service was not responsive.

People's preferences were not recorded or acted upon and their needs were not responded to in a person-centred way.

Few opportunities for personalised social or recreational activities were provided.

Although people were aware of how to raise any complaints or concerns they did not feel they would be dealt with in an open and transparent way.

Inadequate

Is the service well-led?
The service was not well-led.

Staff did not understand their roles and responsibilities.

People could not be assured that the culture of the home was open and transparent.

Inadequate

Summary of findings

There was a lack of application of effective systems to monitor the quality and safety of the home and to manage and mitigate risks.

Orchard House

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 took place on 2 and 5 October 2015 and was unannounced. It was completed by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of residential care service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. The provider completed and returned the PIR form to us and we used this information as part of our inspection planning.

During the inspection we spoke with five people who lived in the home and spoke with seven relatives. We spoke with the registered manager, deputy manager, area manager, four nurses, three domiciliary staff and five care staff.

As part of this inspection we looked at six people's care records and records in relation to the management of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at other information that we held about the home including notifications, which provide information about events that happen in the home that the provider is required to inform us about by law.

Inadequate

Is the service safe?

Our findings

People told us they felt safe, one person said, "I don't worry I'll get hurt or anything like that" and another who told us that, "I'm not in any danger here." However, during this inspection we did not find this to be the case.

Staff told us that they had undertaken training in safeguarding people from harm. However, people were not safe because staff were unable to explain the process to be followed when incidents of harm occurred. During the two days of our inspection we found that there had been seven previous incidents involving people living in the home that should have been reported to the local authority safeguarding team. During this inspection the registered manager referred the incidents we had raised to the safeguarding team.

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

We found that assessments of risk posed to people had not been properly and robustly undertaken. A risk assessment had not been undertaken in respect of one person who had previously fallen from a hoist. However, staff on duty during the inspection were able to tell us how they would transfer the person safely. In another person's care records we saw that they had not been identified as being at risk of falls even though they had experienced three falls. Measures had not been put in place to prevent a reoccurrence of the falls and therefore staff had not learned how to minimise the risk for that person. People were at risk of receiving care that was not safe or appropriate.

Although risks had been identified in relation to people's needs in their eating and drinking, staff did not manage, monitor or encourage people. For example, one person required a fork mashable diet and thickened fluids. However, on the day of inspection we saw the person was given a drink that was not thickened and given biscuits to eat, which was a choking hazard. The biscuits were removed when we reported it to the nurse because they were a food that could not be mashed by a fork. Staff were not able to tell us what foods constituted a fork mashable diet and had not checked with the speech and language therapist who had requested it for the person.

In care records on Lothorian unit, we found that people were assessed as presenting a risk, to the safety of themselves or others, from their behaviour. However, we found that staff had not reassessed the risk to minimise any future events. For example, one person had used the same object to hit other people on two occasions. Staff had not reassessed or learned from the first event to minimise any future occurrence, which meant people remained at risk.

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

Arrangements were in place to ensure medicines were stored securely and medicine trolleys were locked when the nurse was administering medicines to people. We reviewed the arrangements for managing medicines and medicine administration record (MAR) charts. Only nurses administered medication to people in the home and they had been regularly trained and had their competence to administer medicines assessed. One nurse said, "I have had my medicines training but we are all going to have this repeated due to some recent issues." Another nurse stated that they had completed the training two months ago but was still waiting for a competency assessment.

Most people's medicines had been recorded accurately. The nurses did check the MAR charts and medicines blister pack before they administered medicines. We found that the time between the administrations of each person's medicines was spaced to allow the correct and prescribed time to elapse. However, one person said, "They don't do things as they should. It's 10 o'clock and I still haven't had my tablets."

One of the nurses responsible for administering medicines on the day of the inspection did not always follow good practice for administering them. Our observation showed that the nurse did not ensure they washed or sanitised their hands after administering medicines from one person to the next, even though they confirmed with us that that was the procedure they should follow. This put people at risk of contracting someone else's health care associated infection. This was also not adhering to good infection prevention and control practice.

There was no information in the provider's medicine administration policy of what action nurses should take if they found a gap in the MAR charts. During this inspection we found two gaps on the MAR chart and the nurse told us they spoke with the nurse, who should have signed the MAR chart, and told them to sign the chart on their return. The registered manager stated that this was not the

Inadequate

Is the service safe?

expected action that should have been taken, but was unable to provide evidence on how it would be recorded or actioned. As a result staff were unclear of the action they should take.

The registered manager told us there were regular audits to check and reconcile medicines in the home, and that when issues had been identified action had been taken. In addition as a result of the audits findings, the frequency of audits had been increased.

The area manager stated that a recognised tool for staffing levels based on peoples assessed needs was used in the home. However, we saw that the home did not always provide enough staff with the right skills or competence to keep people safe.

People told us they felt staff rushed them when helping them during personal care because they (staff) were short of time. One person said, "I get a bit anxious that there might be no-one [staff] around; say if I want to go to the toilet. The other day the nurse said it wasn't convenient to take me to the toilet when I asked. She wasn't being nasty, she was just busy." Another person said, "I do sometimes have to wait when I ring my bell [emergency call bell], but I can't really complain. The worst is when you are in the lounge area as there isn't always someone [staff] about and you can sit there for a long time before a carer appears." One relative of a person on Lothorian unit said, "I was with [family member] in the lounge for half an hour and not once did they [staff] come over to check him."

We observed that emergency call bells were answered within five minutes. However, people on Rivendell unit were not always able to reach the emergency call bells in some of the bedrooms, communal areas, toilets and bathrooms. This meant they could be at risk if they fell or became unwell and required urgent assistance.

Care staff we spoke with told us about their recruitment to the home. They told us that they had to provide evidence of their previous employment history with an explanation for any gaps. Other documents staff provided included recent photographic identity and their fitness to work with people using the service. They also confirmed that they did not start until they had received a valid certificate from the Disclosure and Barring Service, which carries out a criminal record and barring checks on individuals. Information provided by the deputy manager confirmed that all the necessary documents required and full employment checks had been undertaken for the most recent staff employed in the home.

Inadequate

Is the service effective?

Our findings

The home was not effective because people were not appropriately assessed for their capacity to make day-to-day decisions. Where people lacked capacity decisions taken in their best interests were not formally recorded and they were at risk of being unlawfully restricted.

Neither the registered manager nor the staff had received training in the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS). The registered manager said they had written mental capacity assessments for all people in the home. However, staff were unaware of any assessment or best interest decisions, and therefore the principles of the MCA were not understood or applied. For example there were no assessments in relation to individual, specific decisions, about the need for personal care, assistance with continence management or people's likes and dislikes of food or drinks. People's capacity to make such specific decisions had not been assessed to ensure that their rights were promoted and that any decisions about their care reflected their best interests.

We found that where people lacked the mental capacity to make decisions about their medicines, there were no clear procedures for administering medicines in line with the Mental Capacity Act. For example, we saw that people were given their medicines without a mental capacity assessment and best interest decision being made. This meant that nurses were unlawfully administering medicines outside the current legislation.

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

We found that restrictions were in place to prevent people from leaving the home. This included coded door locks which were in place on the first floor. People living on Lothorian unit were not able to leave unless accompanied by staff. The registered manager said that 12 DoLS referrals had been made to the appropriate authorities, but that all 12 referrals had been returned to the registered manager as the information sent was not complete. Two further DoLS applications had been made and the registered manager was awaiting the outcome.

The provider did not have policies in place in the use of restraint. However, there was information in one person's chart, that recorded behaviour that challenged, that showed they had required three staff to 'get her off' the victim. This indicated that the person may have been restrained. No staff in the home were trained in methods of restraint and this was confirmed by the staff, regional manager and deputy manager. No staff were able to explain the event or provide any other records about the incident.

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

During lunchtime in the dining room on Rivendell unit on 5 October, we saw that five people were able to eat their lunch independently. We saw that when people left the dining room staff helped them to do this. However, staff did not promote people's food and fluid intake and did not ask if people wanted any more food or drink. We saw that some people left the dining room having not drunk anything from the drinks they had been given and this had not been noted by staff. This put people at risk of not having sufficient hydration.

People told us the food was "repetitive" and "not interesting". One person told us, "The food is just awful. It doesn't seem to matter what's on the menu, it just seems to taste the same." On the second day of inspection we saw that the meal of chicken stew, mash potato and Brussel sprouts, was not well presented and staff were unsure what the meal was when they served it.

Staff told us that people had a choice at supper time but there was only one main dish at lunchtime, but if they (people) did not like the meal they could ask for something else. Only one person we spoke with confirmed this and said, "I didn't want the option so I have had an omelette." Only people who were able to request a change of meal or knew they could ask for something different did so. Another person said, "The menus on the table's and on the board are wrong. We don't get two choices [of food]." Although staff told us people were asked what drinks they wanted, one person told us, "I like water to drink, but they always dump this fruity, sugary drink on me, even though I want water." This meant the choices people made were not always provided.

During the lunchtime on Rivendell unit on 2 October the meal was delivered to people pre plated and covered. We ate a meal with people and found the food to be hot. One relative, whose family member was on Lothorian unit

Is the service effective?

commented, "I don't really think [family member's] food all needs to be liquidised. I think it's more about feeding [family member] quickly. They rush [family member's] feeding." Staff brought people their lunch, said the person's name and then left. There were no other interactions with people. One person said, "They [staff] used to sit with us but now they go off and do their own thing." Another person said, "The only company we have at lunch is the TV." We observed another member of staff enter the dining room, collect some items and then leave. They did not engage with people at all. They did not ask after people's wellbeing. This meant that the dining experience for all five people was not a social and as positive an experience as it could have been.

Relatives told us they thought staff were well trained to provide the care people needed. One relative said, "The staff are well trained and go about their duties as you'd expect." Another relative commented, "The carers know their jobs and how to do their tasks." Staff told us that the provider's mandatory training included subjects such as moving and handling, safeguarding people, health and safety and infection prevention and control. Staff told us that they were supported to gain additional health care related qualifications if they wished. One member of staff said they had benefited from dementia champion training and it had helped them to recognise the different stages of dementia and when they would need to involve other professionals such as speech and language therapists or the dietician.

During the inspection we found that although staff had completed training in a number of areas, this was not always well demonstrated by staff practices. For example, although nurses and carers had undertaken training in understanding dementia there were few occasions when people were communicated with or included or encouraged to make their own choices in a meaningful way. One nurse said, "I love the residents, I try to make the carers educated about dementia." However the same nurse went over a person who is living with dementia to check a bandage; they went up to the person and started looking at the leg without speaking to them or to explain what they were doing.

We saw that there was little communication between people and staff and even when there were opportunities, they were missed. Where care records had been written about communication there was little evidence that they provided staff with the information necessary to communicate in a meaningful way with people. For example one care plan showed that the person was unable to verbalise because of living with dementia. However there was confusing information about noises they made and body movements, whether they were a method of communication and if so what they meant. One relative told us their family member understands a great deal more than people think. They said, "That's what makes me sad, that the staff don't make that bit more effort to communicate with her. They don't seem to talk to her. When a carer found the time to chat to [family member] and hold her hand it made me feel good and [family member] too." We saw that staff did not have the necessary understanding to apply the training they had undertaken. This was demonstrated in their approach to the care and support people received.

Staff had received an induction. One member of staff said, "My induction lasted about two weeks. It included classroom training as well as shadow shifts. I was confident that with support I can do this job. If I need any support at all I just ask and I get it."

People's health and welfare was not always appropriately monitored or dealt with. For example, on Lothorian unit we saw that one person had a bandage on their leg but the nurse and deputy manager were unaware the person had a wound. There was no wound chart to ensure the wound was dressed appropriately or when it would need to be changed. The deputy manager stated that dressings that required to be changed were recorded in the diary. However there was no record that anyone on Lothorian unit required dressings to be changed within the next month. This meant people were at risk of wounds not being appropriately cleaned and dressed. One person on Rivendell unit said, "If I need to see a doctor it is organised." We checked on the files of people living in the home and there were details of GP and District Nurse visits. Where necessary we saw that people were referred to community psychiatric nurses involved in their care. Appointments for other health professionals such as dentists and opticians were recorded.

Inadequate

Is the service caring?

Our findings

We asked people and their relatives for their views about the staff in the home. One person said, "Everything is done to you here. I don't really feel I have a value." One relative said, "No way are the residents encouraged to be independent. I suspect it's quicker and easier to do it for them [people living in the home]." Another relative commented, "Two of the staff are wonderful. They are very caring and kind and give 100% because for them the support of residents [people living in the home] is their motivation. Without them the place is poor, as other's [staff] don't give that, as they are focused on getting their jobs done."

One person on Rivendell unit said that a staff member had made them feel better, "I felt a bit miserable. The carer said, "Would a hug make you feel better" and she gave me a squeeze, and for me that made all the difference." However we observed that staff did not always promote a caring approach, When staff spoke with people they often did not use their names. They just communicated information such as, "It's lunchtime so it's time to go" or, "Come forward for me" when asking a person to walk into a different room. One nurse on Lothorian unit told us that if someone was upset a member of staff would sit and talk with them about their life or maybe paint their nails. However, we witnessed people repeatedly calling out who were left in their bedrooms on their own.

We asked people and their relatives how they had been involved in planning their care and how their views were acted upon. Some care plans on Rivendell unit contained a limited life history of the person they were supporting. Examples about information included, "Life history can be obtained from the person or their relatives." This limited what staff knew about the person or how to support the person to be involved as much as possible in their care planning. This also meant staff were less able to respond appropriately to people's needs. There was no information, within the care records we reviewed on Lothorian unit, about people's personal histories so that staff could engage meaningfully with people who were living with dementia. On both units the subjects about hobbies and interests that were important to people were not recorded in sufficient detail to enable staff to provide interesting and meaningful activities. Staff told us there were methods they used to communicate choice to people but this was not seen during the inspection. For example, staff told us picture menus were used to ensure people could make meal choices. However these were not available and not used for people living with dementia on Lothorian unit. This meant people were not enabled to express their views or involved in making decisions about their care and support.

People were not always enabled to be as independent as they could be. For example a member of staff told us that one person liked to use their fingers to eat as they could not use a knife and fork. We were told that the person was not given foods that they could eat independently and told, by staff, "No we feed him." There was a lack of understanding about how people with dementia could be encouraged to remain as independent as possible. We saw that, where possible, people were supported to be as independent as they could be with the administration of their medicines. For example one person, who had arrived in the home for a short stay after a hospital admission, had told us that they administered their own medicine.

People told us, and we saw, that staff provided care in a task centred way and meant people's experience was not always positive. We saw few examples where staff spent meaningful time with people. Some staff sat with people and engaged in polite and respectful conversation, holding their hands and offering support. However, during our SOFI observation in Rivendell unit lounge on the 5 October 2015 we saw that the interactions between staff and people living in the home did not focus on people's wellbeing. For example moving and hoisting people with no verbal reassurance or the reason for the move being provided. We saw that whilst staff respected people's dignity they did not explain or speak quietly to the person about what they were doing or why. One example was when a person's clothing had moved and meant staff needed to physically move the person so that they could readjust the clothing. No words of support or encouragement were provided until the end of the move when staff said, "There you are, all done." Staff were heard to use negative phrases with people such as, "You can't do that" and in one instance staff called a person a disrespectful name.

During the inspection we observed how people's dignity and privacy was respected by staff members. We saw that staff knocked and waited until the person agreed they could enter their bedroom. Staff described the different methods they used to respect people's privacy and dignity.

Inadequate

Is the service caring?

These included closing doors and curtains, reassuring the person and having clothes and towels in place as soon as these were needed when providing personal care. One staff member said, "I care for people as if they were my own [relatives]." We saw that staff supported and cared for people in an unhurried manner when, for example, taking a person to go to the toilet.

On Lothorian unit however, we observed one nurse walk up to a person and give them their medication from a pot without saying anything to them. Their response when asked why they had not spoken to the person and explained that their medicines were about to be given was, "He recognises my uniform and knows he has to take it." During our observations on Rivendell unit we saw that the nurse told people, "Here are your medicines" and, "I have your medicines". The nursing staff then went on to praise the person by saying to the person "good girl" on three separate occasions. This was not a respectful term to use to an adult and did not promote the persons dignity. Another person was being supported with their topical eye creams. The nurse did not explain what this was for or for which eye the topical cream was for. This was not as respectful as it could have been.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives confirmed that visitors were welcomed in the home at any time.

Inadequate

Is the service responsive?

Our findings

Staff were not responsive to people's needs or preferences. Two relatives commented that staff had no idea of their family member's likes and dislikes. One said, "They [staff] just seem unaware of the emotional needs of the residents. I'd say they react to things, rather than are ahead of the game [being proactive]."

Care plan documentation about people's care and wellbeing was incomplete and there was a lack of guidance for staff to follow about meeting people's needs. The deputy manager told us that care plans were being re written. One person said, "I don't think they [staff] have any real idea what I am like as a person or what my interests are." Another person said, "No one asks me what I think about anything." Four relatives told us they were not aware of any care plans and had not been involved in reviews with their family member or asked to provide information to staff. When we spoke with one person they explained that they had problems with their hands and feet and would like a massage. However, they told us they had not had a review about their care to discuss their current needs nor spoken with staff to ensure a referral could be made. In one person's care records there were no care plans about the person's moving and transferring, skin integrity, or oral care. However, staff were able to tell us how to care for the person but there were some differences in what they said.

People told us they had not been involved in their care reviews. We saw that although reviews of people's care had taken place, in some cases that was over a year ago. The registered manager told us that that reviews of all care plans were in progress, but was unable to tell us when they would be completed. Despite these reviews and changes to people's healthcare and support needs, we found that the care plans had not been updated with sufficient information. For example the care records for one person showed that they required staff to support them with their mobility and in other records indicated that they were fully mobile and needed no support. There was evidence that changes to their health condition meant that they now required a wheelchair at times. This put people at risk because their care needs were not up to date and inappropriate care could have been provided by staff.

Where people experienced behaviours which could challenge others this had been recorded. However, there was no guidance for staff on what the most appropriate response was, what action they needed to take or any calming or distraction measures. This meant that the responses to people's care needs would not be as safe, caring or responsive as they could have been.

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

People were not provided with individual activities or opportunities. Although there were two staff employed to involve people in their individual interests, the activities provided were limited. The registered manager told us a new member of staff to provide activities was in the process of being employed. One person on Rivendell unit said, "I would like to go outside the home occasionally, but it doesn't seem possible." Another said, "We used to have the opportunity to do knitting but that stopped. There's absolutely nothing to do here. Don't you believe any lists that tell you things go on. You just look around today and you'll see what I mean. I used to sing but that stopped." On 2 October there was supposed to be a music activity in the morning but it had not taken place and staff were unable to tell us why. There was supposed to be a library session in the afternoon and that also did not take place. This meant no activities took place on 2 October. There were photos on some of the bulletin boards on each floor that recorded places people had visited but we noted that the last outing was in March 2015. The notice board indicated that on 5 October an activity to play a card game was to take place, but Bingo was in progress. One nurse on Lothorian unit told us that one person liked to clean so they had bought her an old fashioned hoover and encouraged her to dust. The nurse stated that people painted, did flower arranging, listened and were involved in music, crafts, planting flowers, cooking, playing chess, attending church services, shopping and bingo. However there was no evidence to show that activities took place on a regular basis or were interests that people wanted to take part in. On 5 October we saw a game of 'play your cards right' on Lothorian unit. We saw that there was very little interest from people living in the home but the member of staff for activities did try to involve people.

The provider had a complaints procedure in place. Information from the provider showed that there had been six complaints since January 2015 and that the staff had followed the process expected. Two complaints were still being investigated at the time of the inspection. Four complaints had been investigated and concluded.

Inadequate

Is the service responsive?

Information had been provided to the complainants to evidence what had been done. This involved further staff training in moving and transferring and catheter care. However some people told us they were not comfortable to raise any issues. One person said, “I don’t feel I can complain because I’m a bit concerned about what they might think of me.” Staff knew how to respond if they received any complaints.

Inadequate

Is the service well-led?

Our findings

The home was not well led as staff roles and responsibilities were unclear to people in the home, their relatives and to us when we arrived for the inspection. Arrangements to cover absences of sickness or holiday for the registered manager or deputy manager had not been addressed. On the 2 October the registered manager was on leave and the deputy manager was not in the building when we arrived. Staff in the home were not aware of who was in charge whilst the deputy was away. The area manager was aware of concerns about clear management structures being in place and changes were being made to improve the leadership of the home.

People we spoke with felt that the management and leadership in the home were poor. One person said, "I can tell you with absolute confidence that there is no-one in charge." Another person said, "I hardly ever see the [registered] manager. That can't be a good thing can it? He should be around talking to us and watching what's going on." Relatives told us they were unhappy with the way the home was managed and commented that the registered manager was never in the home and they were not sure who they would speak to if the registered manager was not around.

There was a lack of systems for monitoring the quality and safety of the service people received and for learning from findings. People told us they had not been asked about the quality of the home. The lack of robust quality assurance systems meant that there was a risk that areas for improvement would not be effectively identified and actioned. One relative said, "No-one here asks you for your views on anything."

The provider and registered manager had not always completed audits and this meant they had failed to identify a number of issues in the home. For example reports of behaviour that challenges people and others had not been checked because we found a possible unlawful restraint that had not been addressed. Information about incidents that had been recorded had not been referred to the appropriate authorities to protect people from harm. We saw that recent audits for medicines administration had not been fully completed although they had identified some discrepancies. We saw that the frequency of these audits had been increased to daily, although they were only starting on 5 October. This meant that the audits the provider had in place were not as effective as they could have been. This also limited the provider's ability to respond to situations as effectively as they could have.

Records did not demonstrate that people had received the care that they required. We looked at records in relation to people who required support from two care staff to change their position in bed. Staff told us that they did reposition people but did not always remember to record the changes. This meant the records were incomplete and showed that people were left up to eight hours before they were repositioned. One nurse stated that no one had a pressure sore and those at risk who were being nursed in bed had a turn chart in place and were turned every two hours, however the records did not confirm this.

Despite a number of other health and social care professionals providing support and information on how to improve the home, these things had not been addressed to make any changes. We concluded that the management of the service had not fostered a culture that was person centred, open and which improved the quality of care and their practice in response to concerns.

There was a culture of blame that was noted by relatives we spoke with. One relative said, "[The registered manager] seems to blame them [staff] when things go wrong. That's why staff change so regularly." Another relative told us that staff sat together at the end of a shift to write their notes, and said, "They take no notice of the residents [people living in the home]." The relative felt the manager should have been aware and made sure staff were available to provide care. The manager commented to us, "I have spoken with staff many times" but no improvements had been made. This indicated to us that the manager was unable to effectively improve the quality of the home. Most people and their relatives said they would not recommend the home to other people.

Staff were aware of the providers whistleblowing policy but said they would not raise any issues as they did not feel any concerns they raised would be listened to or dealt with openly by the managers in the home. One issue discussed by a staff member during the inspection has been raised with the area manager to deal with.

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

Inadequate

Is the service well-led?

Some staff we spoke with told us they could access support from the registered manager whenever this was needed. They said, "[Name of registered manager] is available when you need them. They do work some night shifts as well as popping in on a weekend." Another staff member said, "It is very much a team effort. As soon as I started they [registered manager, nursing and care staff] supported me."

We checked whether the registered manager had told us about incidents happening within the home and which must be notified to the Care Quality Commission (CQC). We found that they had made the necessary notifications of deaths and other incidents to CQC.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not involved in the assessment of their care and treatment. Their needs and preferences were not consistently provided by staff.** Regulation 9 (3)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not treated by staff in a caring and supportive way to ensure their dignity and respect.** Regulation 10 (1)(2)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People were not protected because care and treatment was not provided by staff who were acting in accordance with the requirements of the Mental Capacity Act 2005.** Regulation 11

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. People's risks of pressure ulcers, behaviour that challenges people and others and moving and transferring were not properly assessed and managed. Regulation 12 (1)(2)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services and others were not protected because staff did not understand their roles and responsibilities to prevent and respond to harm. There was a lack of effective systems and processes to investigate and respond to allegations of harm. Regulation 13 (1)(2)(3)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were controlled and restrained without the required authorisation ender the Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice and the Mental Capacity Act 2005 Code of Practice. Regulation 13 (4)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

There was a lack of established and suitable systems for assessing and monitoring the quality and safety of the service and for identifying and managing risks. The registered person did not act on feedback obtained from interested parties to improve the service and to evaluate and improve practice.

Regulation 17 (1)(2)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.