Mimosa Healthcare (No 4) Limited (In administration)

Sandhall Park

Inspection report

Sandhall Drive
Fairfields
Goole
Humberside
DN14 5HY
Tel: 01405 765132
Website: www.mimosahealthcare.com

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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

The inspection took place on the 26 January 2015. The inspection was unannounced. At the last inspection the service was fully compliant with the regulations we looked at.

Sandhall Park is registered to provide accommodation and care for up to 50 older people. The service is a purpose built, single storey care home with car parking to the side and rear of the property. There were 48 people living at the home at the time of our inspection, some of whom had dementia care needs.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

During our inspection we identified 13 breaches in the Health and Social Care Act. This included care and welfare, safety and suitability of premises, safeguarding people from abuse, cleanliness and infection control, management of medicines, meeting nutritional needs, respecting and involving service users, complaints, consent to care and treatment, staffing, requirements relating to workers, supporting workers and assessing and monitoring the quality of service provision. These ranged from minor to major concerns. You can see what action we have told the provider to take at the back of the full version of the report.

We found that people were not always kept safe. Staffing numbers were insufficient and this was impacting on the care and support which people received. Not all people felt safe or confident in raising issues around their safety.

Risks were not always appropriately managed. Although accidents and incidents were recorded they were not analysed to prevent re-occurrence. A high number of falls were happening and the registered manager had not taken action to try to prevent them.

Recruitment practices did not follow company procedures and appropriate checks were not always completed.

Medication systems required review. Medication was not appropriately recorded and it was not clear if medicines were being given as prescribed.

Some of the maintenance checks were not up to date and we found some unpleasant odours in parts of the home. A major programme of redecoration was underway.

Staff did not always receive induction, training or supervision to support them in their roles. Training was not up to date and from our observations the quality of the training needs to be considered.

There was no dementia care model and little evidence to suggest that current guidance or research was being considered or that staff had the knowledge, skills or experience to provide safe, effective care for people.

Consent was not always gained and staff demonstrated little or no understanding of the Mental Capacity Act 2005. There was little evidence to demonstrate that people were involved in discussions regarding their care or treatment.

Staff did not demonstrate appropriate skills or knowledge when supporting people with distressed or anxious behaviours. This meant that people's safety could be compromised.

The dining experience for people was poor with little in terms of choice. Mealtimes were task based rather than social opportunities for people and staff failed to respond to people's requests.

The adaptation and design of the premises was not suitable for people with dementia care needs.

A major programme of redecoration and refurbishment was taking place.

People did not always receive appropriate care which met their needs. Care was task based and we observed examples where staff failed to respond appropriately to people's requests for help.

People's privacy and dignity was not maintained and people were not treated with respect. There was little evidence to demonstrate that people were offered choice.

People had their needs assessed and care records were available. Some of these records were not up to date and did not reflect people's individual needs.

Social activities did not take into account people's likes, dislikes and preferences. There was very little in terms of meaningful activity or social stimulation available.

The complaints procedure was not displayed and people told us they were not clear of who to complain to. When people raised concerns they were not responded to appropriately.

Some people did not know who the registered manager was. The home was not well managed and staff were not displaying appropriate values and behaviours.

Summary of findings

Quality monitoring systems were ineffective and did not bring about change and improvement.

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.

Staffing levels were not assessed and were not sufficient to meet people's care needs. They impacted on the care people received.

The systems, practices and staff interactions observed throughout our visit meant that people's safety or welfare could be compromised.

Inadequate

Is the service effective?
The service was not effective.

Staff did not receive induction, training, support or supervision which supported them in their roles and this was demonstrated in their practice and approach to the care, treatment and support people received.

The manager was aware of the Mental Capacity Act (2005) and the need to determine if care or treatment was being provided in people's best interests. However staff were not clear of the principles of the Mental capacity Act and had not received training to enable them to support people who were unable to make decisions for themselves.

People's experiences at mealtime were poor with a lack of choice. Mealtimes were not pleasant social experiences.

Inadequate

Is the service caring?
The service was not caring.

People were not treated with dignity and respect and care was task based.

Some of the practices observed during our visit may impact on people's care and welfare.

Inadequate

Is the service responsive?
The service was not responsive.

Care plans did not always evidence the most up-to-date information on people's needs, preferences and risks to their care

People did not always know how to complain and complaints were not effectively managed.

There were not enough meaningful activities for people to participate in to meet their social needs; so some people living at the home felt isolated.

Inadequate

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

People were put at risk because systems for monitoring quality were not effective. In addition, there was no way of assessing staffing levels against people's needs, this meant there were not enough staff on duty at certain times.

Inadequate

Sandhall Park

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 26 January 2015 and was unannounced. The inspection was carried out by three inspectors from the Care Quality Commission (CQC).

Prior to the inspection we looked at information held about the service. This included notifications and other information for example, safeguarding information. We had received concerns about how people were being cared for and about numbers of staff on duty.

As this inspection was bought forward based on concerns that CQC had received, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with eight people living at the home, six relatives and/or friends and we interviewed three staff. We also spent time with the registered manager and deputy manager and the manager of another home who was providing support at the service.

We looked at three staff recruitment records, training and supervision records, four people's care records, medication records, policies and procedures, activity records and a number of quality monitoring documents.

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 also spoke with the local authority safeguarding team and with commissioners of the service.

Inadequate

Is the service safe?

Our findings

People provided mixed views regarding whether or not they felt safe. Comments from people included "I feel safe yes. No-one has been unkind and if they did I would complain to X (a member of staff). I use a hoist for manual handling. I feel safe when being hoisted as the staff tell me what they are doing first." Three people told us that they would not report an incident if staff were unkind to them. This meant that people may not always feel confident in raising concerns regarding their safety. Their comments included "Carers, some are alright, some are not. Some want to have their own way and are not very nice. Best just to keep quiet." "Carers are generally very good, sometimes a bit snappy."

Two people expressed concern about an individual who lived at the home stating that they found them intimidating and they said this made them feel anxious. This situation was exasperated by the limited number of staff as it meant people were left unsupervised which increased their anxiety. We observed the lounge on Jasmine unit which we saw was left unstaffed for long periods (one for over thirty minutes) and we overheard an altercation between people living at the home. We provided reassurance to people who appeared upset and anxious in the lounge as there were no staff present.

We also observed people in this lounge trying to get up unsupervised. One individual was trying to pull themselves up with their frame which was the wrong way round. This meant that they were very unsteady and we had to intervene and turn the frame around as this person was at an increased risk of falling.

We looked at the home management tool to see how many staff had attended safeguarding vulnerable adults training. Thirty four of the fifty staff were recorded as having completed this training. Of those, twenty four had completed the training in August or September 2013 which meant that the training had not been updated in line with the company policy which stated this training must be updated annually. We spoke with staff about safeguarding and about managing difficult situations. Although staff said that they would report safeguarding incidents the practice observed during our visit raised concern in this area. We observed one staff member raising their voice and we saw others respond to people in an abrupt manner. We shared this with the registered manager and said that this needed to be dealt with via safeguarding vulnerable adult's procedures. We spoke with a staff member who told us "I did safeguarding vulnerable adults training with my previous employer, but nothing here."

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at how risks were managed within the service. We found that for some people risk assessments were very basic and did not provide clear guidance on how risks should be minimised. Some of the risk assessments in people's care files were incomplete and others did not have a review date. Although accidents and incidents were recorded there was very little in terms of analysis for trends or patterns. This meant that risks may not be being minimised.

We looked at falls records. A high number of unobserved falls were happening and when we looked at the records we found that a high proportion of these were happening between the hours of seven pm and seven am (when only four staff were on duty). The registered manager had not analysed this information or reviewed staffing levels or considered the environment as a way to minimise the risks of people falling. This meant that risks were not minimised.

Some people told us they had a lockable bedside table which they held the key for. Others told us they could have a key for their room if they wanted it. People liked this as it meant they could store items safely.

We looked at the maintenance certificates. The fire extinguisher check was dated 16/08/2013 which meant it was out of date. The legionella check was dated 12/06/2013 which meant this was out of date. We looked at the fire risk assessment which was dated 2011. There was no evidence of this being updated or reviewed since this date. This meant that equipment may not be safe or fit for purpose.

The home had an emergency on call arrangement. This was provided by the registered manager and deputy manager. However the effectiveness of this on call needs to be considered following a review of staff rotas where gaps were identified.

We looked at staff rotas for the service. On the day of our visit there were five care assistants and two senior carers on duty. One staff member had rung in sick. In addition the

registered manager and deputy manager were on duty along with a number of ancillary staff which included domestic and kitchen staff. There were four staff on duty overnight. We saw from rotas that staff numbers fluctuated.

People were not safe as staffing levels were not assessed and monitored to ensure they were sufficient to meet people's needs. We observed call bells ringing for long periods during our visit and saw that people were left alone for long periods in communal areas. People living at the home, relatives and staff raised concerns about the current staffing levels and said that they were not sufficient. Comments included "Carer's are nice and pleasant but not enough of them. You can never find anyone." A staff member said "Staffing numbers are poor. Most people need support from two staff. We are run off our feet." We observed a number of situations throughout our visit where there were insufficient staff to care for people. This impacted on people living at the home as they were not able to gain the support they needed. A relative said "I think staff are stretched, bells are not always answered quickly." When asked, the registered manager could not tell us what system they used to ensure there was enough staff to meet people's needs.

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

Due to the significance of our concerns we have issued a warning notice in this area.

We looked at the recruitment files for three staff. The company policy given to us on the day of our inspection stated "No candidate should commence employment until the DBS First check has been obtained. If a person is employed before DBS is back they must work supervised and their supervisor must be indicated on the off duty." The policy also stated that two references must be received before staff can commence employment.

For two of the three recruitment files viewed, no DBS had been obtained. The current staffing levels meant that staff could not always work in a supervised capacity and there was nothing recorded on the off duty to demonstrate this. This meant that company procedures were not being followed. We also found that one person had been employed without two references being obtained.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at medication systems within the home. We found that hand written entries were not signed by staff and there were gaps on the Medication Administration Records (MAR) recording sheets. For example information regarding the person's GP, the start date of prescribed medication, any allergies and the person's date of birth.

There was a boxed medication sheet which was used as a precaution to record daily stock checks on boxed medicines. However there were gaps in the recording and we also found that the stock counts recorded were incorrect which suggested that staff were recording on the sheet without counting the actual number of tablets. We saw that some signatures were missing from MARS which meant it was not clear if people had received their medication as prescribed. We found that one person had been prescribed antibiotics yet when we checked the amounts of the tablet against what had been prescribed and administered, we found one tablet too many. Incorrect codes were being used on MAR charts for example one chart had the code A for refused yet staff were recording R. This was further complicated by the different MAR sheets in use as they had different codes in place.

We found that some prescribed medication for example; topical ointments such as creams were not recorded as given at all. If medication is no longer required then the home should be asking the GP to review this. We saw that when pain relief medication was administered staff were not always recording the amount given which meant that it was hard to keep an accurate record of medicines.

The medication returns were kept in a filing cabinet. The returns book was completed when medication was returned but not when retained in the filing cabinet which meant there was a risk that medicines could go missing.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the safety of the premises. Maintenance checks were completed and we saw records of these. Staff did tell us that some of the equipment would benefit from being modernised an example given was a new hoist. We

Inadequate

Is the service safe?

found that not all maintenance checks were up to date. This included a check of the fire equipment and the legionella check. The registered manager told us that the fire equipment was going to be checked the following day.

We looked at infection control practices. The home had a policy and some basic cleaning schedules in place. However we did notice some unpleasant odours in some areas of the home which the registered manager was trying to address. A major programme of redecoration and replacement of carpets and furnishings was underway which will help to address this problem. A relative told us that the home was dirty when they visited over the weekend. We saw some examples of areas which were not clean. For example over bed tables where the side strip had come off making effective cleaning difficult.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

Staff did not receive appropriate induction, support and training to help them carry out their roles. We looked at records of supervision and found that these were not up to date. We looked at the induction, training and supervision records for three staff and also looked at the home management tool which records all training and the supervision plan which was displayed within the office. We saw that none of the new staff had been added to this tool so were not receiving any supervision. We spoke with two staff members who both confirmed that they were not receiving any supervision.

Induction was poor. One person told us that a new staff member had been sent in to support their relative despite it being their second day. We spoke with staff who confirmed that their induction had been very basic and covered areas such as fire safety and premises but very little else. The registered manager told us that they were trying to access the company induction programme but that they were having difficulties doing so.

We looked at the staff management tool which is used to record training. Of the 50 staff employed we saw a number of examples where their training was not up to date. Examples included 25 staff not receiving training in falls prevention and only one staff member receiving this training in 2014, 23 staff not receiving training in dementia and only 13 staff receiving this training in 2014. 20 staff not receiving training in health and safety and 16 receiving this training in 2014 and only 19 staff receiving training in infection control 16 of whom received this in 2014. The registered manager told us that training was due to be updated every year. This meant that staff may not have the necessary skills and knowledge to carry out their roles effectively.

We asked the registered manager about the dementia care model in use at the home however there was no model currently in use. There was very little to evidence that best practice guidance was being followed or that staff had the knowledge, skills and experience to support people effectively. The registered manager told us that dementia training was being considered for managers. It was clear from our observations that staff did not have the necessary knowledge and skills to care for people appropriately. For example the poor way staff supported people living with dementia. The lack of choice and opportunity for people to make decisions. The records of activities for people with dementia care needs demonstrated that staff did not understand how to support them or how to provide meaningful activity.

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

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA (Mental Capacity Act 2005) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests. The registered manager told us that restrictions were in place for two people under the DoLS legislation and that a further two applications had been made.

Some reviews of people's mental capacity had been undertaken in relation to DoLS. This meant people's rights against inappropriate restriction of liberty were protected because appropriate measures were in place to make the required assessments and applications, in line with MCA and DoLS legislation. However, staff were not clear of the principles of the Mental Capacity Act 2005 or about making decisions in people's best interests. Staff had not received training in this area. We spoke with a member of staff who said "I have not heard of DoLS and I haven't done Mental Capacity Act training." Other staff members were not clear what this meant or why it was important.

We found that consent was not always gained. There was very little to evidence that people were involved in decisions regarding their care. Although some people had signed their agreement to their care records, some people said that they had not heard of their care plan and we observed staff sitting alone when writing up information about people rather than trying to engage them.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also found that staff were not appropriately supporting people who demonstrated distressed or anxious behaviours. We heard a staff member shouting "Out" to an individual who was distressed in a communal area. This meant that there was a lack of positive actions when

dealing with difficult situations which could potentially cause harm or compromise people's safety. One staff member said "One person is difficult. It's scary. We can't keep people safe."

We observed numerous occasions where staff failed to respond appropriately to people's distress. Care records re-iterated this. One person's care record made reference to the individual being distressed in their room. Staff recorded their response which was to "shut the door."

We saw people pulling at furniture, shouting and causing alarm and distress to others. Yet staff failed to provide appropriate reassurance and support and we had to intervene and provide support to individuals who were distressed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the mealtime experience for people on both units and we spoke with people to gain their experience of the food provided. One person told us "I asked for gammon and pineapple to be put on the menu. I get this now. The meals are alright. " Another person said We all have our likes and dislikes. There is not always much on offer if you want an alternative." Other comments include "Food is good, they feed you well" and "Lunch is too close to breakfast." Most people told us they were offered a choice. However people were asked to complete a menu choice on a morning for the rest of the day. This meant that people often did not remember what was originally ordered or may change their mind and our observations confirmed that this caused difficulties at mealtimes.

We observed some negative examples of people's dining experience. We observed someone asking what the meal was, when told they said "I don't like that", they were then given that meal which they again said they didn't like. They were told "Come on eat it up" at this point we intervened and asked why this person could not have an alternative. We also observed other people stating they did not want their meal and being told to "Eat it up."

Although some people had nutritional assessments in place these were not always up to date and the information within them was not always accurate. This meant that people's nutritional needs may not always be monitored appropriately and managed.

We saw that people were given a drink at lunchtime although they were not offered a choice. We saw one person asking for dessert. The staff response after ignoring them the first time was "Yes I heard you the first time ok. You don't need to keep saying it." The dining experience was not positive for people and there were very few interactions between staff and people other than people being told to eat their dinner.

The registered manager told us that jugs of water were always available in people's rooms and in communal areas. Although this was evident in some people's rooms this was not evident throughout the home. Some people said "I have water in my room, but I am unable to go and get it."

We observed people being offered biscuits and fruit during the morning trolley; however we did not see snacks routinely available for people. This can be particularly important for people with dementia care needs who may need to eat little and often. Some people said they would like more fruit to be available.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We talked with people about their health needs. Relatives told us that they were kept informed of changes to people's health including any falls or GP visits. All were positive about the communication from the home in this area. However we did observe a situation where a relative asked for the result of a urine test. They had asked for this to be carried out the day previously and although it had been recorded in the diary it had not been completed. This meant that people's health needs may not always be responded to appropriately.

We saw some evidence within people's care records that their health needs were being monitored. Relatives were positive about the input from other professionals and all those spoken with said that the home kept them up to date with any changes in health needs.

There was some evidence in care records that people's health needs were being reviewed although there was not always evidence to confirm that any identified action had been taken. However, during our visit we observed two people telling staff they felt unwell. The response from staff was "Come on eat your dinner." They did not respond to what the individuals were saying.

Inadequate

Is the service effective?

Some people had patient passports in their care files. This provides information should a person need to move between services for example if admitted to hospital. However these were not available for everyone.

People's needs were not met by the adaptations and design of the premises. The registered manager had not considered dementia research in terms of promoting a positive environment for people living there. There was very little in terms of sensory objects for people, signage was poor and although memory boxes had been purchased many of these had not been filled with items of importance to the individual. Although some bedrooms had been personalised to reflect the individual, others had not. We also found that the layout of rooms was not always appropriate, particularly for those with physical difficulties.

The registered manager told us that they were aware the environment was not suitable for people living with dementia and said they hoped to make improvements to make it suitable for the people accommodated. They were hoping to contact a University to seek further guidance on improving the environment for people with dementia care needs.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service caring?

Our findings

Most people told us they were treated with kindness and compassion by the majority of staff. However observations made throughout our visit did not support this. We observed a number of issues which may impact on peoples care and welfare. This included the tone and manner people were spoken to by staff. We observed people being ignored asking staff for attention and we saw staff responding to people and their relatives in an abrupt and unhelpful manner. Call bells were ringing for long periods which meant that people had to wait for their personal care needs to be met.

We received mixed views from people and their relatives about the care provided. Some people expressed very positive feedback but others thought that staffing was impacting on the way in which care was being delivered.

Our observations demonstrated that care was not person centred. It was very task based. Staff confirmed that the current staffing levels were impacting on care delivery. They said this impacted on how often someone had a bath or how quickly bells were answered. We saw that people were still being got up at lunchtime and this was confirmed by some of the staff we spoke with. There was little recorded in people's care files about their life history or things which mattered to them.

During our observations we saw that people were left unsupervised for long periods. Staff failed to check on people in lounges and we had to intervene on a number of occasions to maintain people's safety.

However we also saw and were told of positive examples regarding people's care. A relative said My relative is always nicely dressed, with clean clothes and their hair done."

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

There was little evidence available to demonstrate that people were involved in making decisions and choices regarding their care. People were not supported to have access to advocacy services and there was no information displayed regarding this. There were gaps in some of the care records we looked at and we found that care records did not reflect people's views or wishes.

People's privacy and dignity was not promoted. We saw a number of people wandering around without tights, socks or slippers. One person was wearing only one slipper. They asked the inspector to help them. When we asked staff to intervene the response was "it's in the wash."

They made no efforts to find alternate footwear or find a solution.

A GP arrived during our visit. The staff member shouted across the dining room the reason why the GP was visiting which did not promote the individuals dignity.

During our observations across both units we identified some concerns about the way in which people were spoken with. Staff tone was abrupt and people were ignored. Staff did not appear to have the skills to manage those with anxious or distressed behaviours. Staff did not promote respectful and compassionate behaviour, instead they were rushed, hurried and on occasions were abrupt with those they supported.

We observed staff interacting with people throughout our visit. Although we saw some positive examples we also saw numerous examples which were not positive and may impact on people's dignity. This included ignoring someone who was asking for help and not responding to someone when they said they did not want something.

Relatives raised concern about items which were missing. One relative expressed concern regarding a lost hearing aid and missing teeth. The person without a hearing aid could not communicate with their relative when they visited which was distressing to them both. People also expressed concern about missing items of laundry.

There was very little to demonstrate that people were being offered choice. For example at lunchtime everyone was given the same drink and people were told where to sit.

We spoke with a member of staff who told us "We have a senior carer who makes people get up early. They ask me to wake people. I have raised this with the manager but nothing happens." The staff member did tell us that they refused to do this.

We saw that a bath list was displayed in the office with each person recorded as requiring a bath on a set day each week. This is institutionalised practice and does not promote choice or dignity. We looked at three people's daily care records. The records of baths, nail cleaning etc.

Inadequate

Is the service caring?

were poorly completed and it was not clear if these tasks had taken place or not. We saw that some people had baths recorded only twice in January and bed changes only twice. Another person only had one bath recorded in January and no nail care. Their relative expressed concern about the standard of nail care stating that they had needed to clean their relatives nails themselves.

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

Inadequate

Is the service responsive?

Our findings

The people we spoke with told us that they could make choices and examples given included the time they wanted to get up or go to bed. One person told us "They always check before providing care. Never make you do something. They don't bamboozle you." Others told us that they could make choices with regards to their daily meals.

People had their needs assessed although these were basic and some areas of the assessment were not fully completed. Care records required additional work to reflect the individuals accommodated. For example one of the care plans we looked at had a falls risk assessment and falls care plan which contained only basic information and had no review date.

Care records did not demonstrate that people's views and wishes were sought in terms of their individual preferences, wishes and aspirations. We found that information was lacking from peoples care files and there was little to reflect people's life history or what was important to them.

Some people had memory diaries but there was no information recorded within them.

If the home gained information about people's life history then staff may be able to connect with people in a meaningful way. We saw from records that the same activities were repeatedly offered to people even when it was quite clear from the recordings that they did not want this. Some people were withdrawn when we carried out our observations. This can be a sign that they are disconnecting with the world around them which can be a result of insufficient stimulation. If staff are going to provide meaningful activities to people then they need the necessary skills and knowledge to do so.

Although some social activities were available these were limited and we saw lots of entries in people's activity records which said "Unable to sit still and join in activities." "Unable to communicate, very little co-ordination and unable to do activities but enjoys sing song and church services." "Joins in less and less, happy to chat but doesn't understand or talk." This demonstrated that staff did not have an understanding of how to provide meaningful activities to people living with dementia.

During our observations we found that people were sat with nothing to do. There were no magazines or books for people to look at and other than the television there was nothing for people to engage with. This meant that people were bored and that they may be socially isolated.

There was little to demonstrate that people were able to follow their interests and take part in meaningful activities. Staff said "Socially there is little going on. Most people just sit here." It was clear that activities were not based around the needs of people living with dementia.

This is a breach of regulation 9 of the Health and Social care Act

We asked to look at the complaints procedure. This was not displayed in communal areas for people to access and people spoken with told us that they did not know who to complain to.

The policy was dated 2010 and there was no evidence to say it had been reviewed or updated. The policy did not include contact details for people. The registered manager told us that the complaints policy was included in the welcome pack given to people on admission. However, not everyone knew how to make a complaint or raise a concern. In addition, people told us that they were able to make everyday choices, but we did not see this happening during our visit.

However despite the lack of up to date procedure and the concerns raised form some relatives about who to complain to, the majority of people spoken with said that they did feel able to raise concerns directly with staff.

We observed a relative ask a member of staff about batteries for a remote control. The response from staff was "I don't deal with batteries." This demonstrated that staff were failing to respond to people's needs. The relative told us "My relative is dependent on the television for company as they decline to come out of their room. The remote has not worked for four weeks." We saw from the complaints file that the response to complaints was not always recorded. This meant that there was an ineffective system in place in regard to the comments and complaints made by people.

This was a breach of Regulation 19 of the Health and Social Care Act.

Inadequate

Is the service well-led?

Our findings

The home has a registered manager. Staff and relatives said that they would like the registered manager to be more visible. For example; relatives raised concerns about staffing levels and cleanliness during the weekend, however the registered manager told us they did not work weekends. A number of relatives told us that they did not know who the registered manager was, although most were clear of the senior carers in charge on each unit.

We identified significant shortfalls during our inspection. We found that outcomes for people using the service were poor. There was little to evidence that staff were working towards a set of values that included involvement, compassion, dignity, independence, respect, equality and safety. We observed how staff spoke to people and found that people were not valued or treated in a person centred manner. This included people being ignored, people spoken to abruptly and people who despite airing their views or opinions were not listened to.

We did not find a positive person centred culture which was inclusive and empowering. People told us, and we observed task based care which did not focus on people as individuals. This demonstrated that management had not developed the staff team to make sure that they displayed the right values and behaviours.

Staff expressed mixed views about the culture at the home. Some felt that it was a positive place to work and others felt that changes were required. Comments included “Morale is poor.” And “Morale depends on which day you work.” Some staff said that concerns which had been raised with their manager had not been appropriately addressed.

We asked one staff member about senior management and if they would know who to go to outside of the home. They told us that when senior management visited they did not speak with staff. This meant that they did not feel that leaders were visible or approachable.

Although the home had a number of quality monitoring systems in place which were identifying issues of concern there was a lack of ownership in terms of addressing them and the areas identified in our inspection suggest that the current quality monitoring systems were not effective in driving improvement. For example, a number of required improvements were identified in the audits being completed by the registered manager, yet there was no evidence to demonstrate that improvements were being made. Management and staff did not understand the principles of good quality assurance which meant the service lacked any drive for improvement.

There was very little evidence to demonstrate that people and staff were actively involved in developing the service. Relative meetings were not held and people told us that they did not feel confident in raising concerns. Although staff meetings were held some staff told us they did not feel confident in raising issues. There was little evidence to demonstrate how people and their relatives were encouraged to view their opinions or to make suggestions for improvement.

Records at the service required further development and review. They were not person centred. They were not being reviewed regularly and were therefore not fit for purpose. Policies and procedures were not being followed and they required review and updating.

The systems in place did not demonstrate that the registered manager was measuring and reviewing the delivery of care against current guidance.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person is failing to take steps to ensure people are protected against inappropriate or unsafe care or treatment. Regulation 9 (1) (a) and (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person is failing to ensure that people are protected from the risks of unsafe or unsuitable premises. Regulation 15 (1)(a) and (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person is failing to protect people from the risks of abuse. Regulation11(1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person is failing to assess the risk of and to prevent, detect and control the spread of infection. Regulation 12.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person is failing to protect people against the risks of unsafe use or management of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person is failing to ensure that service users are given a choice of suitable and nutritious food and hydration in sufficient quantities to meet their needs. Regulation 14(1)a.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person is failing to provide an effective system for identifying, receiving, handling and responding to complaints. Regulation19(1)(2) .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person is failing to ensure that there are suitable arrangements in place for service users to consent to their care or treatment. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person has failed to operate an effective recruitment procedure. Regulation 21(a)(b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person has failed to ensure staff receive appropriate training, development and supervision. Regulation 23(1).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People were not protected against the risks of inappropriate or unsafe care or treatment as the provider had failed to implement an appropriate system to regularly assess and monitor the quality of service provision.

The enforcement action we took:
We have issued a warning notice to be met by 15/03/2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The provider had failed to make proper arrangements to ensure the privacy and dignity of service users.

The enforcement action we took:
We have issued a warning notice to be met by 15/03/2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider has failed to ensure that at all times there were suitable numbers of suitably qualified and skilled staff to safeguard the health, safety and welfare of service users.

The enforcement action we took:
We have issued a warning notice to be met by 15/03/2015.