Care Quality Commission

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Alsager Court Care Home with Nursing

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 5 and 18 May 2015. The inspection was unannounced. The last inspection took place in July 2014 when the registered provider was found to be meeting all the requirements for a service of this type.

Alsager Court Care Home with Nursing is part of the Blanchworth Care Group and is registered to provide accommodation and personal care with nursing for up to 27 older people. There were 22 people living in the home at the time of this inspection.

The home provides care in a large single story bungalow in its own grounds in a residential area of Church Lawton near Alsager. All of the rooms are single and 16 of them have ensuite facilities.

At the time of the inspection the home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

Although people told us they felt safe, we found that there were insufficient staff to provide a safe service to the people who lived in the home and that this was particularly so at night. The home depended upon a high proportion of agency staff and this meant that there was less continuity of care than there was when permanent staff were on duty. Agency staff also seemed to be less reliable and so staffing levels could be severely reduced at very short notice.

We found that medicines were not managed safely at the home and risks were not always properly managed. Systems were not robust enough to ensure that people living at the home were protected against the spread of infection. Arrangements for eating and drinking did not take account of individual needs and requirements although most people we spoke with said they enjoyed the food.

The registered provider did not provide the people who lived in the home with the protection afforded by the Mental Capacity Act 2005. The home was not well adapted to provide services for people living with dementia. There was a lack of activities, care was not planned around individuals and there was insufficient signage. Confidentiality was not always observed in the storage of records.

A new manager had just arrived at the home and was making arrangements to address some of the shortfalls we identified. However on the days we inspected the home the quality assurance and monitoring systems had not been sufficient to identify matters which required management action to improve them. Recent progress had not been sustained.

We identified breaches of the relevant regulations in respect of person-centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users, meeting nutritional needs, premises and equipment, good governance, and staffing.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe because there were not sufficient staff (particularly at night) to make sure that people could be looked after all the time. Sometimes the provider depended upon too many agency staff who did not always have the detailed knowledge required to care for people in the home.

Staff had a good knowledge of safeguarding procedures as they related to the prevention of abuse. However medicines were not properly managed in the home nor were some other risks. Some parts of the home did not have an adequate hot water supply and attention was needed elsewhere to reduce the risk of infection. Better signage was needed and the current system for locking bedroom doors needed urgent review.

Is the service effective?

Inadequate

The service was not effective because people did not always receive food and drink in the right way or with the correct assistance. Staff were not always available to give people the help they required at mealtimes. Changes were needed to the physical environment to make it suitable for people living with dementia.

Although a significant number of people in the home were living with dementia the registered provider had made no applications to the local authority for authorisations to detain people under the Deprivation of Liberty Safeguards requirements.

Is the service caring?

Inadequate

The service was not caring because care was not always provided to people in a timely manner or when they requested and needed it. Although staff tried to observe practices which would preserve privacy we found that at times dignity was compromised.

Most of the people who lived in the home spoke highly of the staff and the care they provided. However staff were sometimes not sufficiently familiar with the content of care plans and these records were not always stored securely. Sometimes care did not meet people's needs.

Is the service responsive?

Inadequate

The service was not responsive because there were no activities in the home and there was insufficient personalised information about people for meaningful activities to be organised for them.

The processes for responding to complaints were not sufficiently robust to ensure concerns were appropriately addressed and used to improve the service.

Is the service well-led?

Inadequate

The service was not well-led because there had been no registered manager in post for nine months. The current manager had only been in post for a few weeks.

Quality assurance systems were not effective in making sure that the service provided was of an adequate standard. Recent improvement had either not been sustained or had reversed.

Alsager Court Care Home with Nursing

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

The inspection took place on the 5 and 18 May 2015 and was unannounced. The inspection team for the first day was made up of two adult social care inspectors, a specialist adviser in mental health and services for older people and people living with dementia, 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 care service in this case people who are living with dementia. On the second day the two adult social care inspectors visited again.

Before the inspection we reviewed the information the Care Quality Commission already held about the home. We contacted the local authority safeguarding and commissioning functions and they shared their current knowledge about the home.

During the inspection we spoke with eight people who used the service together with six relatives. We talked with six members of staff as well as the manager and the quality assurance manager for Blanchworth Care Group (the registered provider). We looked at seven care plans as well as other records and audit documents. We looked around the building including, with the permission of people who used the service, bedrooms.

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 to us. Following the inspection we spoke with the Cheshire Fire Brigade as well as the Cheshire East Council Congleton and Sandbach Adult Social Care Team.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. They said "Yes, yes – very safe. They take wonderful care of you". A relative told us "(The staff) are OK – you get the odd ones who are a bit sharp but they are short staffed so you can't blame them really". Another person said that when they asked for something "It might take a bit of time because there aren't many of them (staff) ….but they bring it when they can".

Another person told us "You see they (the staff) are short staffed. You have to wait a bit but it's not their fault you know". They told us they did not think there were enough staff and added "Definitely no!" and told us they had to wait for their call bell to be answered – "Sometimes half an hour and even longer – they don't answer instantly". A relative told us they did not think that there were enough staff "because they can't give them (the people who used the service) the attention when they need it all the time- you can hear the buzzer (call alarm) now". We heard a call arm sounding for some time before being answered.

We arrived to start the first day of our inspection at 6.45 am. We checked the level of staffing that had been on duty in the home and found that this had been made up of one nurse and one member of care staff since 11 pm the previous evening. There was a marker board in the main office which showed the names and overall care requirements of the 22 people who were living in the home. We could see from this that a number of people needed the assistance of two members of staff. With this level of staffing at night it was clear that where both staff were attending to one person others would have to wait for care. Staff confirmed that this was the case. We saw that during this time there were other pressures on the two staff on duty such as attending to medicines and attempting to clear laundry.

We were told that this staffing level caused most difficulties where there were people who were living with dementia and who liked to walk around the home at night. When this happened staff could not give them enough attention. This was illustrated by an incident which had occurred just before we arrived in which one person had entered another person's bedroom whilst they were asleep and had urinated there because they were looking for the toilet. There were insufficient staff to prevent this kind of incident occurring and consequently people who lived in the home were not safe. When we asked staff if they thought that people in the home were safe all of them cited low staffing as presenting a risk to people's safety.

The day shifts at Alsager Court Care Home with Nursing were scheduled to begin at 7 am and we were told that the usual day time staffing complement was one nurse and four care staff. However by 7.30 am on the first day of the inspection there were still only two care staff on duty together with one nurse. We were told that there should have been agency staff on duty but that they had not yet arrived. We knew from our records that this situation had also happened some months before and the home had been left severely understaffed because agency staff had not materialised. Staff had alerted the manager to the current situation by text message.

We saw that on the first day of our inspection the home was very dependent on agency staff. These are staff who are employed by a separate organisation which provides staff to any service which requires them. The staff can be working in different homes on a day to day basis and so there can be a lack of continuity for the people who use the service as well as the staff themselves. Agency staff are trained by their employer not the home in which they work and so there can be variation in standards and working practices.

We found that the agency staff we spoke with were less knowledgeable about the people who lived in the home and were general unwilling to engage in discussions with us in detail or even in some instances to give us their names at all. One agency worker told us "(The permanent staff) work here all the time so it is not for us (agency staff) to say and then just leave them (the permanent staff) to sort it out. We (agency staff) come and go". Another told us that they did not read care plans because "they are not for agency staff". We could see that staff were very busy throughout out inspection. One described themselves as "shattered" and was perspiring and breathless with the amount of work they had to do.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sufficient numbers of staff were not deployed to meet the needs of the people living in the home.

When we visited the home on the second day we found that the day time position had improved. We found that the

Inadequate

Is the service safe?

atmosphere was less fraught. When we asked staff why this might be they told us that the proportion of staff on duty who were permanent employees of the home was much higher and this led to a much greater level of teamwork amongst them. The registered provider had also arranged for one-to-one staffing to be provided for the person whose behaviour had caused difficulties during the night. However this was only a temporary measure whilst the provider made arrangements for this person to be moved out of the home.

We looked at the arrangements for administering medicines in the home. We found a number of discrepancies in the two records we inspected. We saw that medicines had been prescribed on a PRN or "as required" basis. We found that there were no written protocols in place which would help staff to know when these medicines should be administered nor was there an indication in some instances of the maximum amount of medicine that should be given in any period of time. We saw that other medicines had been prescribed and then administered but the time they were given had not been accurately recorded. This meant that the next dose might be administered too early because some medicines require the correct gap between them. In other instances medicines had been prescribed but there was no record that they had been given.

Some people had been prescribed ointments or creams but records of how and when these were applied were inadequate. There were instances where there was no count made of the medicines held on behalf of the person and so no reconciliation could be made of the stocks retained on their behalf.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a safe way for service users because medicines were not managed safely and properly.

We saw that the home included various risk assessments in the care plans such as relating to falls, weights and nutrition. However we could not always reconcile all the information we found. For example one person's skin condition needed to be checked daily but we could find no record that this had been done. Someone who required this would also need regular monitoring using an assessment tool such as the Waterlow scale. We could not find evidence that his had been completed in April. The records of this person's weight were incomplete and had been recorded inaccurately.

During the day we saw instances where the lack of staff led to poor or dangerous care practice. One person's care plan stated "Staff to sit her (this person) upright prior to eating". When we saw this person served with their lunch we saw that they were lying almost completely prone when the food was put in front of them. We pointed this out to a member of staff but later saw that this person was alone again and still lying nearly prone. Staff told us they did not have the time to attend to this person. The lack of attention to an appropriate eating position put them at increased risk of choking. We brought this matter to the attention of the manager.

On another occasion we saw a single care worker attempting to help two people at the same time. They were pushing one person in a wheelchair whilst supporting another to walk. They reached a point where they were no longer able to support both people and had we not been present one of them would have fallen.

The risk assessment for the person who had entered another person's room the previous night stated that this person should be observed when walking around, should be observed at all times and accompanied when going to the toilet. These precautions had clearly not been in place when the incident took place.

We were concerned that we could find no analysis of one person's behavioural difficulties which sometimes posed a risk to other people who used the service as well as staff. Such an analysis (sometimes known as an ABC chart) can help staff to recognise any factors which might contribute to the build-up to such an incident so that they can avoid these where possible. The same analysis can also help clinical staff such as psychiatrists or psychologists to consider how best to help a person to manage this behaviour. We saw that the local mental health team had recommended the completion of these charts as well as implementation of a care plan but we could not find any of these documents.

Inadequate

Is the service safe?

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a way so as to mitigate the risks to the health and safety of people who used the service.

Incidents where staff and the manager had been assaulted and injured were not recorded in the accident book and there were no other records. These incidents posed a risk to people who used the service as well. Safeguarding referrals had not been made to the local authority or notifications to Care Quality Commission.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not operating appropriate safeguarding procedures.

We asked permanent staff about how they had been recruited to work in the home. They confirmed that they had been required to complete an application form, supply references, and apply for a Disclosure and Barring check so that any criminal convictions could be considered. On this occasion we were not able to check any of these documents since they were kept at the head office of the company which owned the home and this was based in another part of the country.

All the staff we spoke with understood safeguarding procedures and reported receiving training in this. They were also aware of whistleblowing which is what happens when a member of staff wishes to report something to an agency outside the organisation they work for.

We were aware that there had been a recent infection control visit to the home. A representative of the local Clinical Commissioning Group had toured the home with a member of senior staff and pointed out items which required attention. We saw a number of these items which had still not been attended to. The cutlery tray in the dining rooms was stained and dirty and the shelves of a dresser on which crockery and glassware were stored were dusty. Some of the waterproof seals in the bathrooms were worn and discoloured and needed replacement and there were gaps where pipework was not properly boxed in both of which represented infection hazards. An empty urine bottle had been left lying in one of the bathrooms apparently still in the same position since being reported some weeks previously.

The surface of the wall in the laundry room was cracked and represented an infection hazard and a mop with a full bucket of dirty water had been left in the hairdressing salon which was being used to store the cleaner's trolley. On the day of our inspection the sluice room was cluttered with equipment which had been emptied from the bathroom next door which was being modernised to form a wet room. No attempt had been made to prevent people from entering this room whilst the building work was taking place and there was no signage to indicate that the room was not in use as a bathroom. This represented a hazard to people who used the service.

We pointed these out to the manager who told us that she had not been provided with a record of the infection control visit. By the time we returned on the second day of the inspection we could see that some attention had been given to items such as moving the urine bottle and dusting the shelves. A notice had been placed on the new wet room indicating that it was not in use although the door was still unlocked. This still left a number of items from the visit which required attention in order to limit the risk of infection.

We tested various taps to see if there was adequate hot water. In some rooms the water had to be run off for some time but eventually the water ran hot. However in the sluice room where commodes were disinfected after use there was no hot water supplied for hand washing and in two of the bedrooms there was only a trickle of water from the hot taps. The people who occupied these rooms did not therefore have direct access to any hot water with which they could wash. Staff who had undertaken personal or disinfecting tasks would have to travel to another room to find running hot water before they could wash their hands. When we returned on the second day we found that there was no hot water in the sluice room and some taps did not supply any water at all. We were shown records that suggested that this had been an on-going problem from some time which the registered provider had not satisfactorily resolved.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a safe way for service users because the risk of infection was not controlled.

We were concerned to note that the bedroom doors each had a cylinder barrel which operated a Yale-type lock. This meant that the door could be opened from the outside

with a key which was hung up on the outside of the door. Although this was intended to dissuade an unauthorised person from using the key we were not convinced that this would be effective. We were concerned to note that these locks still had the snib mechanism for securing the door from the inside and that when used this rendered the external key inoperative. This would mean that a person living in the home could secure themselves in their bedroom and staff would have no means of gaining access to the room in an emergency if the person was sick or if there was a fire.

Staff told us that there had been a recent incident when a person had locked themselves in a bedroom in this way. Staff told us that they had to effect an entry to the bedroom by climbing through the bedroom window from outside. This would have involved removing the window retainers. We were told that this incident had occurred when the person concerned had become convinced that the whole of the home was their house and that all the other people and staff in the building should not be there. Apart from the physical risk to this person of being locked inside a room from which they could not easily escape, the rescue would have been frightening in itself and all the more alarming given their confused state. We were concerned to find that the manager was unaware of this incident. We pointed out our concerns to the manager.

When we returned to the home on the second day of the inspection we saw that some of these locks were being replaced with similar locks but without the snib mechanism. We were concerned that this still meant that in order to escape from a bedroom such as in case of fire, a person would need to have the manual dexterity to operate both the lock and the door handle. We did not think that people and particularly those living with dementia would be able to easily operate these mechanisms. We have referred the matter to the Cheshire Fire Brigade which has confirmed that they will visit the home in order to ensure that any arrangements comply with their regulations. A relative subsequently contacted us because they were concerned that the removal of the snib mechanism meant that their relative would be effectively locked in their bedroom because the locking mechanism could no longer be disabled as they preferred. We informed the staff on duty at the home of their concern.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The premises were not suitable for the purpose for which they were being used.

Inadequate

Is the service effective?

Our findings

We asked people what they thought of the arrangements for eating and drinking at the home. One person told us "I love the sandwiches at tea time …. my favourite meal is tea …. I have dinners too. It's all home cooked". They told us the food was nice and that "I have a choice. They always ask". One relative told us that they thought the food was "nice", that people were given "a couple of choices" and that people were asked what they would like.

We looked at the arrangements for eating and drinking at Alsager Court Care Home with Nursing. On the first day of our inspection when there were fewer staff the dining room was sparsely furnished and at breakfast we saw that the tables were bare except for some mugs which had been placed on each of them. We saw that before lunch the tables had been laid with cutlery as well as a table decoration.

We asked what time lunch was served and were told 12.30 pm but on the first day of our inspection we saw that people were not brought to the dining room until 12.50 pm and that it could take as much as another 25 minutes for people to be served. On the first day of our inspection meals were still being served at 2 pm. There was a choice between two dishes and people were able to express their preference for which meal they would like on the day. We saw that the menu was displayed on a chalkboard as well as in the entrance to the home but most people did not look at this but instead were asked their choice by the staff in the dining room. Meals were sourced ready prepared from a frozen meals company and heated on the premises. This was at odds with the claim made in promotional material for the home which we found in the entrance and which referred to "home cooked food". We were told that the kitchen was able to adjust supplies to reflect demand for different dishes expressed by the choices that people made.

There was no cook on the first day of our inspection but this role was being fulfilled by a member of staff who was otherwise employed as a domestic in the home. It was clear that preparing the meals single-handed for the people who lived in the home was found to be stressful on a day when there were few permanent staff and the staff group as a whole was under pressure. We saw that care staff were not in evidence within the dining room other than to escort or bring people into it.

Where one person needed assistance this was provided by another member of domestic staff who told us they had worked in the home for many years. We saw that they took care to wear an apron and assisted one person to eat their lunch in a way that was caring and kind. Apart from this, however, there was little other interaction for the people in the dining room either with staff or with each other. The only other member of staff in the dining room was a regional manager who told us they had been brought into the home because of our visit. We saw that one person did not touch their meal for around 20 minutes but there was no encouragement or enquiry made as to their wellbeing. This person ate a little of their first course only and then left the table and the dining room. No one showed any interest in this or enquired as to whether they might prefer a different dish or were feeling unwell.

A number of lavatories opened into the dining room and during lunch we saw one member of staff assist a person to the toilet before resuming serving food. This left the remaining people without staff support including one person whose care plan said they had difficulty with swallowing.

We saw one person who was served lunch in bed. No staff remained with this person to assist or encourage them to eat. We pointed this out to a member of staff who called in to see this person who had then started chewing on the call bell. When we raised this with the care staff whom we had spoken to before they told us that they could not devote more time to helping this person because they were so busy with other demands on their time.

Another person told us that they received a pureed diet despite their protests and claimed that they did not have swallowing difficulties. Staff confirmed that this person had been put on a pureed diet despite their objections and they showed us the pre-prepared pureed food that they were served. Later in the day we observed a senior member of the management team giving this person cheese and biscuits which seemed inconsistent with the staff view.

We could see from this person's care plan that they had been prescribed thickener in their drinks but their care plan did not mention a pureed diet. There was no evidence that this person had been involved in developing their care plan and although it was clear that they were able to make their wishes known their views were not being taken into consideration. They had not been given explanation or

reason why they had been put on a pureed diet and in the absence of an assessment as to why they had been the manager was unable to justify why this was being done against the person's wishes.

Because of the absence of staff and the limited interaction with people who were dining we found this dining experience to be predominantly functional with nothing cheerful, friendly or communal about the occasion. Apart from being asked for their choice of dish, people sat in silence and ate their meals.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nutritional needs of people who used the service were not met.

We were told that a large number of people who lived in the home were living with dementia. We looked at how the physical environment in the home provided for those people. Alsager Court Care Home with Nursing is made up entirely of ground floor accommodation. However different parts of the home were at different levels to each other connected by ramps which have been carpeted. Members of the inspection team found the changes in level to be disconcerting. Although some of the ramps had temporary signage attached to the nearby wall we did not think this was sufficient for people who might have cognitive difficulties such as people living with dementia.

We otherwise saw little other signage which would direct people around the home apart from toilet doors which were colour coded in red. Although bedroom doors were numbered and had names on them, these were small and would be difficult to read. There were no themed areas of the home which people could relate to themselves such as where they were born, what they had worked at during their lives, or major events and personalities they might all have had in common.

This was a further breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The premises were not suitable for the purpose for which they were being used.

We looked at training records for the home to see if the provider made arrangements for staff to have the necessary skills to do their job. We were shown records relating to fire precautions and evacuation, hand hygiene, risk assessment, safe use of bed rails, handling of dangerous substances and activities. Training was provided from a number of sources including on-line and in house. All the training except for activities was described as mandatory. Completion dates were generally recorded as within the last two to three years.

We spoke with staff who confirmed that they had received induction training as well as recent training in subjects such as safeguarding but the training records we were provided with did not always reconcile with their descriptions.

We were told that all but four of the 22 people living at Alsager Court Care Home with Nursing were living with dementia and saw that the home had coded locks so as to prevent people from leaving the building. The Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) requires that appropriate authorisations are obtained in order to protect people who are living in these circumstances.

When we looked at the care files we could see no evidence that mental capacity assessments had been undertaken or that the necessary authorisations had been applied for, The manager told us that there were no people in the home for whom a DoLS authorisation had been obtained. Other staff confirmed this. Some DoLS checklists had been completed but the checklists were not constructed so as to allow a decision to be made in accordance with recent judgements about when a DoLS was required. This meant that people's human rights were not being protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005.

Inadequate

Is the service caring?

Our findings

Some people spoke positively about the quality of care and support they received. They told us that they were well cared for and had their needs met and they were content. One person said "I'm very happy, they put me to bed nicely at bedtime, I'm very lucky to have such a lovely place to go to" and I 'wouldn't get the same care at home'. One person told us that they thought that the staff were caring and told us "Oh yes, yes definitely …. there's a personal touch to each one" and that the staff made them happy.

People said that privacy and dignity was maintained through such means as making sure that bedroom doors were shut whilst undertaking personal care tasks. During our inspection staff cited this as one way in which they made sure that people's dignity was respected and we saw staff knocking on bedroom doors before entering. However one person told us that they were given no choice about whether their care was provided by a male or female carer and they were under the impression that this choice was no longer available.

One consequence of using agency staff is that the provider may not always be aware of who is going to be sent to the home. We heard that during the weekend prior to our inspection there had been two male staff allocated as the only staff to cover an overnight shift. The manager told us that when this had been realised a female member of staff had stayed on duty until 2 am but this still left a five hour period when there would have been no female staff in the building at all. This meant that any preference people might have as to the gender of their carer could not be respected.

We started our inspection early in the morning and found that the number and skill mix of staff deployed was inadequate to ensure people's health and social care needs were met.

We could see that staff were prioritising their time and endeavouring to meet people's basic care needs as best they could but there were delays, and some people were still waiting to be attended to late into the morning after 11 am. At 11.15 am two people were sitting by tables in the dining room still waiting for breakfast. The mid-day meal was due to be served at 12.30 pm. At 11.30 am staff had still to attend to a person, who being nursed in their room due to their frailty. This person was still in their room with curtains drawn, lying in bed and hadn't yet been washed.

Other people raised concerns and told us that they did not always have their personal care and health care needs met in the way they would want them to be. We were told that one person had attempted to alert care staff to the need for their catheter bag to be emptied. Their requests had been ignored meaning the task fell to staff working on the next shift. This person was not attended to quickly enough and the catheter bag overflowed. This meant that there was an infection risk and that this person's dignity was compromised. We brought this matter to the manager's attention and they agreed to investigate. We also referred the matter to the local safeguarding authority. This incident had taken place over a weekend. Some staff commented to us that it sometimes felt as if tasks which could be completed on one shift (including laundry) were left to the next shift. Where these tasks subsequently fell on the two night staff it placed further pressure on their limited numbers.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service users were not treated with dignity and respect.

When we asked the nurse in charge and a senior care worker as to the content of one person's care plan they told us that they did not know because they had not read it. They explained that they did not read care plans because they were not reflective of each persons' needs and instead relied on word of mouth as to how to meet people's needs. A further care worker told us that they had never read any of the care plans because they did not have time.

We found other examples of poor communication including important events affecting the safety and well-being of people that had not been brought to the manager's attention. One the first day of our inspection we found that the manager was unaware of incidents that indicated people were at risk of abuse and on the second day of the inspection staff had not informed the manager that a person had symptoms of a possible infectious condition. We found that action had not been taken to ensure people's safety and well-being as a direct result of these omissions.

Inadequate

Is the service caring?

Staff told us that one of the people living at the home presented with behaviour that was unusual or unexpected and several staff including the manager had been assaulted whilst they were trying to deliver personal care. This person's care records did not contain a care plan about this person's behaviour other than a risk assessment which indicated staff should use "divertorial techniques". Staff told us that they did not know what this meant and although they had received some training on behaviour which was unusual or unexpected this had not helped them meet this person's needs safely.

We found that in the absence of a suitable care plan or appropriate guidance on how to meet this person's needs staff had refrained from offering this person appropriate levels of personal care and support. At 2 pm on the second day of the inspection we noted that this person had not got out of bed and a strong and pungent malodour was coming from their room. Staff told us they did not wish to disturb this person but at 4 pm we entered the person's room and spoke with them. They told us that that did not want to comment but we found that their personal care needs were being neglected. The condition in which we found their room was unacceptable, unhygienic and a health hazard.

We brought our findings to the attention of the manager who told us that this person's admission to the home predated their own arrival and they found it difficult to meet this person's needs. We made a safeguarding referral to the local authority because we were concerned that this person was not receiving care appropriate to their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The care and treatment of service users did not meet their needs.

People's wishes for end of life were not recorded in the appropriate detail and it was clear that people were not involved in the development of their end of life care plans. For example, one person had a "do not attempt cardio pulmonary resuscitation" (DNACPR) order document in place at the front of their care records. We saw that the person concerned was unable to be consulted at the time this decision had been made but their circumstance had since changed and they now could be consulted but the decision had not been reviewed.

We asked the manager, a nurse and a senior care assistant whether the DNACPR was in place and they all told us that it was. This meant that the person was at risk of their health care needs not being met in the event of a cardiac arrest. We brought this matter to the attention of the manager. However it was only on the second day of our inspection that action was taken to ensure that the DNACPR was suspended pending an urgent review. This person told us that their ultimate aim was to get better and move on from this home and spoke of their frustration that staff at the home were not open with them about their future. They told us that they had never seen their care plans.

This was a further breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the consent of people in relation to important decisions about their care and treatment.

Care records were kept in a locked cabinet in the main office where people could be assured they would remain secure and staff confirmed to us that they understood the importance of confidentiality. However throughout the inspection we found parts of care records left in public areas. On the first day we found a record of care left on a window sill. This identified the names of individuals and a note of one person's condition. A folder of care records was also left on a radiator shelf in a corridor where any passer-by could read the contents. On the second day of our inspection we found a folder of records which detailed behavioural incidents some which were sexual in nature and therefore very intimate. Each form identified the person concerned by name and had been placed in a folder in the open lounge where any visitor might be able to read them.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not maintain secure records in respect of each service user.

Inadequate

Is the service responsive?

Our findings

People who used the service and their relatives told us that there was a lack of activities in the home. We saw that there was a timetable of activities in the entrance to Alsager Court Care Home with Nursing but we saw none of these in progress during either day of our inspection. We were told that the previous activities organiser had taken maternity leave and that a replacement had been interviewed and was due to start later that month.

Some people who had been assisted to get up were sitting in the lounge. The television was on but no one was watching it. One person cried out to staff and said "I am sick of being here watching that thing all day". A member of care staff team responded to this person's comment, saying "Oh dear". They did not seek further engagement with this person as to what they may like to do but turned the TV off and put a compact disc player on. The disc was faulty and portions played repetitively as a result. During this period the only carer to come into the lounge sat in a chair by the door and did not otherwise interact with the people who used the service.

We spoke with the person who made the comment and asked them whether they were cared for and had any hobbies or opportunities to take part in activities. They said "The staff are OK and the food is very good, I have had a drink and breakfast but there is nothing to do all day just sitting here all day long it makes me angry I'm fed up of it".

Another person told us that there was never anything to do. They said "We get enough drinks but we are just waiting for the next meal that's all - it's boring." They went on to say "Staff are OK but there is not enough of them. They don't have time - they can't be in two places at once. If you ask them for something they do not hear you - they just walk away - they are too busy. I asked for a shower a fortnight ago I have not had one". We checked this person's personal care records and could see that there was no record of them being offered a shower in over a week.

We saw that people who were unable to get out of bed were left for long periods without attention. One person was left in their room in a cold draught because the window had been left open. Another person was not washed in the morning until 11.30 am.

We spoke with staff and asked what provision had been made for activities. They told us that there was no activities coordinator and that they had other priorities to attend to. We looked at the care plans for some of the people who lived in the home. We found that these were in the form of standardised books of pro forma meaning that the same forms were present irrespective of each person's individual needs. There were also multiple copies of blank forms within the care plans. We found that this made it difficult to find our way around them to locate the information we required. We found that there was little personal information about people and their lives such that would allow person-centred care to be delivered. Person-centred care is care which is organised around the person's individual preferences rather than around the needs of the service.

This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The care and treatment of service users did not meet their needs.

We observed that staff were often kind and caring in their approach and the SOFI we conducted on the second day confirmed this. We saw them speaking to people and offering support gently with occasional touches on the arm or gentle guidance and encouragement to enable the person to accomplish the task they had set out to do. We could see that the staff group had a range of caring qualities but they lacked knowledge about each person's individual needs and poor communication between the staff and the manager exacerbated uncertainty and put people at risk of their needs not being met. We noticed also that a number of call bell sockets in common areas of the home did not have a press button plugged into them and so could not be used to call for assistance.

We saw that the provider maintained a complaints log and that there had been seven complaints since the last inspection. Responses to each of these complaints were logged. We noted however that the copy of the complaints procedure we were given did not specify timescales for responding to complaints and that the provider might "defer" anonymous complaints. Anonymous complaints can provide important information about service quality even if the complainant does not wish to identify themselves.

One relative told us that they had complained about the staffing levels and that they thought that some action had been taken as a result of this. However this had not been

Inadequate

Is the service responsive?

recorded in writing nor had any formal response been received. We were aware of relatives' concerns about staffing levels in the home because they had copied us into correspondence with the former manager about this.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the current manager had only been in post for a few weeks. Relatives told us that they had had concerns about staffing in the home and the lack of activities. However they told us that they thought the new manager was "Making changes. Our relative is a lot happier". Staff spoke positively about the new manager. One told us "There's a lot more structure since (the new manager) arrived. Staff know what they are doing – they seem to be helping each other more. They are responding to the call bells quicker".

There was no registered manager at Alsager Court Care Home with Nursing. When we last inspected the home in July 2014 the then acting manager had agreed to register urgently but did not do so. The registered provider had not taken action in this respect. This acting manager had recently left and the current manager had only been in position for three weeks.

We saw that the new manager was using this period of time to assess the service provided by the home and to identify where improvements might be required. The new manager was aware of some of the issues we raised with her and there was evidence that she was formulating responses to them. She engaged with our inspection and the feedback we provided.

We saw that the registered provider arranged for quality audit visits to be made to the home. We saw that these included an inspection of the care provided in the home and followed the format which was taken by the Care Quality Commission (CQC) before the current style of inspection was introduced. We were told that these audit visits were carried out on a monthly basis but the most recent audit we were shown was for February 2015 and highlighted requirements for action in a number of areas although we could not find evidence that all this action had been taken.

For example the audit included a check of whether people had consented to their care but we could find little evidence of this. The audit included nutrition but recorded no observation of a meal time and so it was not clear how this aspect of care had actually been audited or any recommendations formulated. The audit recorded the levels of night staffing that we saw during the inspection but made no comment on or assessment of how this matched the current needs of the people who used the service. Daily care plan checks were identified as needing immediate attention but there was no evidence that these had been completed.

The audit included additional checks following the same structure as the CQC has used for this inspection but the recorded comments did not always identify the action required for example, comments under "well-led" recorded only that the then manager was on annual leave.

We saw that there were a number of other audits which were undertaken regularly in the home. These included a care plan audit, infection control audit, weekly wound audit, quality assurance audit, medication audit and activities audit. We were concerned about the effectiveness of these audits. For example the care plan audit recorded that staff could relay the content of care plans when asked at random but some staff told us that carers "do not use care plans". The medicines audit had not identified the irregularities that we had seen.

The home used a quality assurance tool which asked people who used the service to rate various aspects such as care, laundry, food and activities but the last report we were provided with was dated in late 2013. The home aimed to achieve 75% satisfaction using this tool and aspired to 90%. All areas of the service except domestic services scored below 75% and most areas appeared to have suffered a decline in quality rating at the time the poll was last completed.

We saw that the provider held staff meetings and looked at the records for December 2014 and February 2015. On both occasions staff had voiced concerns about the level of staffing which the then registered manager had passed on to the owners. In December the owners had refused to allow agency staff to be employed. In February an increase to the level of night staffing had been refused although some two hours improvement was made to the staffing arrangements for the evening. This would not have addressed the difficulties we observed in relation to two staff providing care to people who needed both members of staff to meet their needs and people who needed individual attention, both at the same time.

When the provider gave us an action plan following the inspection of May 2014 they told us that they would review all the care plans in the home and provide further training for staff on this aspect of care. They also undertook to

Is the service well-led?

provide nursing staff with training in the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The registered provider undertook to put arrangements in place so that concerns about staffing could be reported to them by the registered manager. The registered provider undertook to review staffing levels on a weekly basis. When we returned to inspect the home in July 2014 we recorded that the manager at the time undertook to develop more person-centred care planning. At that time we also brought problems of hot water supply to the attention of the registered provider.

On the basis of this inspection we found that the registered provider was not making sustained progress of the kind outlined in these plans. We saw no evidence that the registered provider had responded effectively to the concerns about staffing that had been communicated to them. Care plans did not show any improvement around person-centred planning and the absence of DoLS applications and mental capacity assessments suggested that action in this area had been ineffective. There were still major problems with the hot water supply in the home. Whilst we saw that there had been a change in the manager there was no evidence that the registered provider had implemented systems to achieve continuous improvements on a sustained basis.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not operate systems or processes to effectively assess, monitor and improve the quality of the service being provided.

We saw that the new manager was taking steps to improve the service. During our inspections we saw that she was interviewing prospective staff and had already appointed an activities organiser. Although she was about to start a period of annual leave she had made arrangements so that she could be contacted in an emergency whilst stressing that she wished the staff to develop the capacity to respond to day to emergencies without resorting to this.

Registered providers such as Alsager Court Care Home with Nursing are required to inform the CQC of certain incidents which occur within the home. We checked our records of the notifications we had received from the home and were concerned that the home was not making proper notifications to us. For example the incident which had occurred the night before the first day of our inspection was not formally notified to us. We were not notified about the incident where a person had locked themselves in their bedroom. We had no record of bruising which we were told had been discovered by a relative on a person who used the service some months previously and we had not been notified of any of the incidents concerning the persons for whom we had completed safeguarding referrals to the local authority.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.