Kisskadee Enterprises Ltd

St George Residential Care Home

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 26 January and 11 February 2015 and was unannounced. The service provides accommodation for up to 18 older people who may also be living with dementia. There were 12 people living at the service when we visited.

Following an inspection on 17 September 2014 we found five breaches of Regulations and issued compliance actions which we asked the provider to take action on within an agreed timescale. The provider sent us an action plan telling us the action they would take to ensure they met the requirements of the law. They told us they would achieve compliance with the regulations by the end of January 2015.

At this inspection we found the provider had taken steps to make some improvements but these were insufficient

Summary of findings

to meet the areas of concern and were still not meeting the requirements of the regulations. In addition this inspection has highlighted further breaches of regulations.

At the time of our inspection the service had a manager who had just been registered by CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and tolerated some of the shortfalls in staffing and a lack of activities, because they liked the small homelike atmosphere within the service and found it convenient for them, their friends and relatives. However, we found people's safety was being compromised in a number of areas.

The arrangements that were in place to safeguard people from the risk of abuse were inadequate as not all incidents which should be reported to the local authority and CQC had been. The management of nutritional and skin integrity risks and for those living with dementia in regard to environmental risks, or those with other health conditions were inadequate. This put people at risk of serious harm.

The provider did not have a system to assess the number of staff needed and there were not enough staff at all times to meet people's needs. Recruitment procedures did not ensure that all appropriate checks had been carried out or that staff had the appropriate skills to work with people living with dementia. Staff had not received the appropriate level of training to enable them to work confidently and with appropriate understanding of the needs of people living with dementia.

No one living at the service was currently subject to a Deprivation of Liberty Safeguards (DoLS) authorisation, and there was a lack of awareness shown by the registered manager that for some people who did not understand the need for staff to provide interventions in regard to their care and support, a referral to the Deprivation of Liberty safeguards team should have been made. The Care Quality Commission (CQC) monitors the operation of DoLs which applies to care homes and we found that the service was not meeting the requirement of the Deprivation of Liberty safeguards. Mental capacity assessments were not carried out although people who knew people well were involved in their care plans and in making some decisions about their care.

Systems were not in place to ensure that the registered manager and staff had a good understanding of whether people were eating and drinking enough, or steps taken to ensure those who could not be weighed were assessed in some other way. This put them at risk of malnutrition and dehydration.

Staff demonstrated kindness and compassion towards the people they supported, however short staffing led some staff to be less tolerant of those people who required more staff input and monitoring. This was evident in some of the poor practice we saw. There was an over reliance on other people in the service informing staff of the whereabouts of people who needed regular monitoring.

The location of some shared toilet facilities meant people's privacy and dignity was not always maintained when receiving support in communal areas. Some staff attitudes in response to work stresses also compromised people's dignity.

The registered manager had developed and updated 10 out of 12 care plans, those updated were individualised and had been developed with the involvement of people and their relatives however some gaps in regard to risks remained and life histories were still being developed with relative's involvement. Staff did not always follow the care plans so that people could rely on care being delivered in the way they or their relatives had expressed their preferences for. Activity provision was inadequate for everyone but those people who remained in their rooms had very little engagement and mental stimulation and were at risk of becoming isolated.

There was a complaints policy and a system to record and investigate complaints. This was being used for some but not all complaints.

The staff team did not feel well supported through the changes the registered manager was trying to make. Staff meetings were held but staff did not feel these were arranged for the benefit of staff or a forum where they

Summary of findings

could raise issues important to them. There was a lack of a clear staffing structure in the absence of the registered manager and senior carer with staff unclear who was the shift lead and responsible for decisions within the service.

The provider carried out regular visits to the service and completed visit reports but these were not effective had not identified the shortfalls we have found through inspection and were not being used to drive improvement. The registered manager had implemented a robust medicine audit and also a catering audit and we could see where shortfalls were being highlighted but actions taken to address these were evident in records seen. People were asked for their views about the service but did not receive feedback on what the analysis of surveys had shown and how was used to influence service development.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service did not have safe procedures in place for infection control, medicines management, or staff recruitment.

There were not enough staff to provide safe and effective care. Staff did not understand how to keep people safe from harm. Risks to people were not managed to ensure their safety.

The premises were not safe. People did not have access to all the equipment they needed to help their independence or to alert staff in emergencies.

Is the service effective?

Inadequate

The service was not effective

The requirements of the Mental Capacity Act 2005 were not followed. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with the legislation. Care staff did not have an understanding of Deprivation of Liberty Safeguards and did not know which people they applied to.

Staff received training but their records were not available to check whether training was kept updated. There were no systems in place to ensure staff were competent to carry out their roles. Staff competencies were not checked following training.

People enjoyed the food they received but systems to ensure that everyone was eating and drinking enough were not in place. Adjustments were not made to help people with limited capacity make food choices. People were supported to access health care services but staff were not provided with information to support people with their health needs at the service.

Is the service caring?

Inadequate

The service was not caring

People were not treated with respect and their dignity was not upheld. Staff treated people in a directive and paternalistic manner. Some staff spoke to people sharply, and laughed at people in an unkind way.

People or their relatives were not always involved in decisions about their care and treatment.

People spoke positively about the qualities of staff and relatives also said they found staff kind and considerate. People said they could receive visitors when they wanted.

Is the service responsive?

Inadequate

The service was not responsive

Summary of findings

Records of most people's care and treatment needs had been updated with their involvement, but important gaps remained that meant staff were not provided with all the information they needed. Staff practice showed that they did not always adhere to the care record and support people how they or their relatives wished.

There was a lack of activity and stimulation to meet people's individual needs. People who remained in their rooms received very little mental stimulation or interaction and were isolated.

There was not an effective complaints process in place to ensure people could be assured concerns were acted on appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Action had not been taken to address previous breaches of regulations we had identified. Audits were in place, however these were not used to make improvements to the service people received. The system used to assess and monitor quality was not effective.

The registered manager was implementing changes but staff did not feel supported through this process.

St George Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 and 11 February 2015 and was unannounced. The inspection team consisted of one inspector on the first day and two inspectors on the second day. Before the inspection we reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with all of the people living in the service. We spoke with a relative of one person and a friend of another. We also spoke with two visiting opticians. These conversations were to help us understand the experience of all the people who lived in the service. We also spent time observing interactions between staff and people who lived in the service. We spoke with the provider, the registered manager, four care staff, and three of the domestic staff including the cleaner and two cooks.

We looked at care plans and associated records for four people, staff duty and handover records, three staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel safe here and they (staff) always know what they are doing". Another person said, "I am quite happy and think the girls help me with everything I need". "They always help me with my medicines and I get them when I need them". One person said, "This is a marvellous home. I know some aren't so good but I feel safe here". However, we found that people were not protected from avoidable harm and were not safe living at the service.

In September 2014 the provider could not demonstrate they applied safe infection control procedures, and could not show there was appropriate equipment to ensure people's safety and maximise their independence. The provider did not have appropriate arrangements in place for dealing with foreseeable emergencies, and people were not protected from risks of unsafe care because care and treatment records were not maintained accurately, and there was an effective system assessing and monitoring the quality of the service. The service was in breach of regulations 9, 12 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We told the provider to take action to address these concerns. The provider said they would ensure all appropriate actions were taken to address these breaches by the end of December 2014. At this inspection we found that whilst small actions had been undertaken most of the actions which the provider had informed us would be completed had not been done.

There was a step from the hallway to the dining area which did not have a ramp in place. There was a portable ramp which could be used; on both days of inspection the ramp was not used. Staff said this was only used for people in wheelchairs and their practice confirmed this. Staff said that other people in the service with mobility problems did not like to use the ramp as they were afraid that their walking frames would get stuck in a groove in the ramp. We observed people on more than one occasion making their way from the hallway to the dining room by negotiating the step when staff were not always available to support them. There was a handrail to one side but this was insufficient, the depth of the step meant that this posed a risk to people with limited mobility falling on entering or leaving the dining area. Staff themselves told us they saw the step as a major risk to people in the service, however no further action had been taken by the provider to seek assessment of this area from an occupational therapist to explore safer alternatives. There were no current plans to find a longer term solution to the risks the step posed although one person had fallen and injured themselves when trying to use the step. This is a continued breach of Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (d) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A faulty alarm on a ground floor fire door near to a frequently used toilet and the dining room had not been addressed. This meant that people were at risk because they could open this door without alerting staff. Some toilet frames were now fixed to the floor but others in people's bedrooms had not been fixed and this placed people at risk of pulling these over if they lost their balance. Actions to ensure that people could have their bedroom doors propped open safely by the use of fire alarm linked door guards had not been implemented. This is a continued breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 (1)(c)(e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

One person was at risk from falling on the stairs. Staff told us this person never left their room without staff support, but an experienced staff member said that whilst this was generally true there had been a few occasions where the person had been found at the top of the stairs attempting to use the stair lift. The potential for this to happen, and measures to alert staff in good time such as alarm mats to prevent an accident had not been appropriately assessed or implemented and the person was therefore at risk. There were some free standing heaters around the service, including one in the dining area that had not been risk assessed to ensure people were not placed at risk of harm from falling over it or burning themselves. This is a further breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (a) (b) of the health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they liked the small setting of the service which gave them a more homelike atmosphere; they found it was convenient for them and for their friends and families to visit. Individual bedrooms had been personalised by people and/or their relatives. However the premises were in need of upgrade and repair, externally

and internally and there was no longer term plan for the update of the premises that would demonstrate a drive for improvement. Repairs and replacement were undertaken on a reactive rather than planned basis.

On the first day of inspection a gas heater in the dining area was not in use and staff told us this had been condemned by the Gas contractor for some time.

A bathroom on the first floor was in the process of having some works undertaken but this was unfinished and a bucket of nuts/bolts had been left on the floor, posing a risk to people. One bedroom had loose and cracked wall paper, when touched the wall paper pushed in and it was unclear if there was a wider problem that could pose a risk to the health of the person in that room. The wall on the other side of the room was on the stairwell and the wallpaper on the staircase side was also loose with crumbing plaster and the wooden slats could be seen. There was damage to the wall on another staircase. A bath panel in the bathroom used by people was coming loose and posed an infection control risk from spillages leaking under the bath.

There was a maintenance person who undertook minor repairs and visited the service on Mondays and Thursdays. A maintenance book was in place and staff used this to report minor repairs that needed to be fixed. Light bulbs fusing were a common problem and staff told us if a bulb was to fuse on a Monday night it would not be repaired until Thursday. One person told us the hallway bulb outside their room had fused the night before and the hall was in complete darkness, this area of the corridor was dark. Although staff told us they were not allowed to replace light bulbs for health and safety reasons we noticed later in the day the light bulb has been replaced.

There was only one bath with a bath hoist and this was used for all baths. Staff said there was a shower but this was known as the 'staff' shower and people living in the service did not use it. Records showed that not many baths were taking place. Staff told us this was because there was a longstanding issue with the water temperature, this had meant that water was not hot enough and people could not have a bath. A plumber had visited the day previously and fixed both this problem and that of the overflows. Staff told us that there had been an on-going issue with the overflows at the rear and front of the premises. Different plumbing contractors had been unable to rectify the problem. As the overflow at the front of the premises was pouring hot water over the roof and falling to the front of the house, the outside wall of one person's bedroom was water stained and wet and there was green algae growing on the wall indicating this had been happening for some time. We were not satisfied these issues had been fully resolved.

We were informed by the registered manager that temperature checks were made regularly of hot water outlets but when we asked to see the record of checks the registered manager told us these were not being recorded, so there was no means of ensuring that temperatures were being maintained within safe levels. We did test the bath water at inspection of the only bath used by people and this read 38 degrees which was in the safe temperature range, but we did not check other outlets around the home.

The shortfalls identified in relation to the maintenance of the premises are a breach of Regulation 15 Of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 (1) (c) (e) of the health and Social Care Act (Regulated Activities) Regulations 2014.

On both days of inspection works had not been completed to ensure there was a working sluice facility and a hand wash sink in the laundry area. Commodes were being emptied in a first floor toilet that served the bedrooms on that part of the first floor. This toilet had stained paintwork and pipes and damage to flooring which did not provide a proper seal to reduce infection control risks. Staff did not have a specific cleaning protocol in place to ensure the whole toilet area was cleaned thoroughly after the emptying of commodes before it was again used by people, so as to minimise the risk of cross infection. We discussed this with the manager. On the second day of inspection we found the toilet was now out of use and the seat removed meaning people on that side of the building were required to use commodes. However, the door was open and could still be accessed This posed a risk to people who may not understand that the toilet was not in a suitable state to be used.

The provider informed us prior to the inspection that a member of staff had been designated as the infection control lead. Only one out of three staff knew who the infection control lead was and what they were responsible for. All the staff spoken with said they did not receive updates about infection control practice from the infection control lead and were not aware of any infection control

audits being undertaken or their outcomes, they said that infection control matters were not routinely discussed at staff meetings as an agenda item and staff meeting minutes confirmed this. This is a continued breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (h) of the health and Social Care Act (Regulated Activities) Regulations 2014.

People thought the environment was kept clean. One person told us, "My room is cleaned every day and it is always kept lovely". We spoke with the cleaner who told us that previously staff had helped with light cleaning and it was the cleaner's responsibility to undertake in depth cleaning of every bedroom and communal area. The cleaner did not work to any cleaning schedules but to a rota that she had devised herself, she told us that she cleaned each room on a rota basis and usually cleaned three to four rooms per day, she was aware of those people who required more support to keep their personal spaces clean, and provided extra support to them.

One experienced staff member who was providing personal care to a person was not wearing personal protective clothing over their clothing to undertake this task, there was a risk of cross infection between tasks as this staff member was later seen in the kitchen preparing food for people's teas. This is a further breach of Regulation 12 of the HSCA 2008 Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (h) of the health and Social Care Act (Regulated Activities) Regulations 2014.

Records showed two people's care plans were still to be updated to reflect risks they might be subject to. Some individual risk assessments were in place for everyone with others updated recently, but important areas of risk such as skin integrity and nutritional risks were still to be completed in all care records. This is a continued breach of Regulation 20 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (c) of the health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had received training in respect of safeguarding adults but when asked what they thought this meant in everyday practice for them they initially placed emphasis on the need to maintain people's confidentiality rather than the risk of harm to people from different forms of abuse. When prompted to expand on this they were able to explain the different types of abuse people may be subject to, they knew who to report concerns to and that they could also report concerns to external agencies and felt confident of doing so. However, in practice staff did not recognise when incidents that occurred in the service or their practice could be considered abuse, for example, reprimanding a person loudly in front of other people and staff, not giving someone their medicines, or ensuring unexplained bruising was investigated. This is a breach of Regulation 11 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13(1) (2) of the health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager had carried out a medicines audit which had highlighted that staff medicine management practice needed improvement. The audit had identified that some boxed medicines had not been given and staff were not always signing Medicine Administration Records (MAR) to confirm they had administered some medicines. Staff were also still using codes from medicine administration records system used previously, and these did not correspond to the present MAR and did not inform the registered manager why medicines may not have been administered for example if a person was unwell, or had refused medicines.

Actions taken to address the issues' highlighted by the audit were not made clear in the audit record to provide assurance that changes had been made to ensure people's medicines were being managed safely. Changes proposed by the registered manager to improve medicine management including the addition of people's photographs with their MAR charts, were taking time to introduce and risks around staff practice remained. At inspection we undertook a count of the medicines in question during our visit and found these to be accurate. We noted that staff were signing and dating changes that were made to the MAR sheet. Some experienced staff were not confident in administering and so the registered manager often stayed later to administer medicines when these staff were on shift.

Staff used a drugs trolley on the ground floor to administer from. Staff did not always ensure they locked the trolley up when they left it unattended to ensure medicines were kept securely. We found that the temperatures of medicines stored in the drugs trolley were not recorded, although temperatures in the dining area were high at times as a result of heat from the kitchen and a nearby radiator; these checks would ensure that storage temperatures were not

too high to impact on the effectiveness of some medicines. Similarly no temperature recording was made of medicine stocks stored in an upstairs room in with a large window that would attract sunlight in the summer months.

Some boxed and bottled medicines were not dated upon opening which would help the manager when undertaking a medicines audit. On our first day of inspection we spoke with a person about their care and they mentioned that they had not been allowed their pain relief medicine by night staff, even though it was understood this was taken as and when required because of pain. We asked the registered manager about this and why this had happened, we were told that a number of night staff had left and the night staff covering the Friday Saturday and Sunday shifts were mostly agency and not allowed to administer medicines. The registered manager had not ensured the staffing rota for these shifts included staff who were able to administer medicines. On the second day of inspection the registered manager informed us that this had been addressed by having agency nurses on shift on Friday, Saturday and Sunday evenings until the service had recruited and trained replacement staff. We have not seen records to assure us that this has continued.

On the second day of inspection a member of staff was giving out medicines. She sat in front of one person and took the tablets from the pot with her fingers. She then 'popped' them into the person's mouth and then offered them a drink. The staff member was not wearing gloves and this posed a risk to the person and to the staff member of cross infection. One person was administered eye drops whilst sitting at the dining table during lunch. This was disrespectful to other people at the table and also infringed the privacy and dignity of the person receiving the eye drops.

The registered manager and a senior carer were responsible for ordering and receiving medicines into the service, in the absence of both of these there was no clear line of accountability to ensure that someone took on this responsibility. One person administered their own eye drops but a risk assessment was not in place to ensure this was being undertaken safely. This is a breach of Regulation 13 of the HSCA 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (g) of the health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us the staffing levels were inadequate to meet people's needs. They said this was compounded by a difficult building layout. No dependency tool was in use to determine the appropriate number of staff that should be on duty each shift. The registered manager had identified the need for staffing numbers to be increased but this had not happened. Two people required 2:1 support from staff, other people needed assistance from one staff member to get up or go to the toilet.

Staff were constantly busy, and we observed attitudes towards people who were challenging to others were sometimes inpatient and irritable in tone. Although staff also said they missed being able to spend time talking with people, our observations showed that once up and dressed people were left largely to their own devices with most ushered away from the dining area towards the lounge area for no obvious reason.

The layout of the premises meant that when people were in the lounge or their bedroom they were usually out of sight of staff, this was because there were only two staff on duty and throughout the inspection they were seen undertaking tasks elsewhere in the home away from the lounge. People who used the lounge regularly told us that they did not see much of staff during the day except for drinks and lunch time support. For those people who required their movements monitored because they were at risk of falling, there was an over reliance on the people who used the lounge to alert staff when one person in particular was mobilising by their self. One person said, "We phone the staff to alert them when he is trying to walk", and we observed this in practice during the inspection. People in their bedrooms said they did not see much of staff throughout the day. This is a breach of regulation 22 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at recruitment procedures. Records showed that applicants completed application forms and attended for interview. Full employment histories were not available for two staff we looked at and interview notes made no reference to gaps in employment histories to ensure the manager had assured themselves of the reasons for this. Disclosure and Barring checks (these are checks to see whether people have a criminal record) were completed and employment references were sought.

One new staff member who was in their induction period was still without the full range of checks in place, and whilst they were supernumerary to the rota and was not directly

Inadequate

Is the service safe?

working with individual people, there were times when this this member of staff was left alone with people. There was no supervisory plan to ensure this person was always in the company of another staff member. This meant people could be placed at risk from staff who had not been checked to ensure they could work with vulnerable adults. This is a breach of Regulation 21of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (3) (a)(b) of the health and Social Care Act (Regulated Activities) Regulations 2014..

Staff were able to describe the actions they took when a person had an accident or there was an incident that needed to be reported. Staff understood how to seek appropriate support to deal with emergencies, for example dialling for an ambulance appropriately. We looked at accident and incident reports and these had been completed, and we were able to track several recorded incidents/accidents mentioned in handover sheets and daily reports and find corresponding incident/accident reports for these.

Inadequate

Is the service effective?

Our findings

Staff told us that their training was up to date and they had completed training in infection control, first aid, moving and handling, food safety, fire protection and safeguarding, to ensure they had the basic skills and knowledge necessary to support people safely. Some staff said they had also received training for working with people living with dementia, and training in mental capacity. Not all staff training records were available and a request for them to be sent to us after the inspection was not forthcoming. This is a breach of Regulation 20 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2) (d) of the health and Social Care Act (Regulated Activities) Regulations 2014..

A new staff member told us that they were on induction and were shadowing other staff at present over different shifts, they were also familiarising themselves with people, reading their care plans and familiarising themselves with the policies and routines of the service. Another staff member confirmed they had undergone a period of induction during which they had been supernumerary for several shifts and felt they were prepared for working on shift full time.

Staff showed very limited understanding of the Mental Capacity Act 2005 (MCA) and how they need to apply this to their everyday practice. They were unable to demonstrate that the MCA should be used to assess people's capacity to make certain decisions, at a certain time. Staff showed some understanding of the need to ask people for their consent, and care records showed that some consent around photographs and sharing information had been sought. We heard some examples of staff asking people for their consent before care or support was provided.

Capacity assessments were not in place for people who lacked capacity in some areas of their care and support and best interest discussions had not taken place with one exception to inform staff practice. The provider could not demonstrate that relatives had the legal right to make decisions and give consent on behalf of their relatives and this could mean that decisions might not have been taken in accordance with people's wishes or best interests.

The registered manager was aware of the Deprivation of Liberty safeguards (DoLS), but said that she had not kept updated and was not aware of the recent Supreme Court judgement that broadened the interpretation of the use of DoLS. Staff restricted people's choices about where they could spend their time. One person walked into the dining room, but staff asked them why they were there and took them back to the lounge. The registered manager said she had not considered DoLS in relation to some of the people in the service who lacked capacity, and we brought two people to her attention who did not have the capacity to understand the restrictions in place for them and who we thought should have been referred to the local DOLs team. This is a breach of Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the health and Social Care Act (Regulated Activities) Regulations 2014..

People were provided with opportunities to select their meals each day but no adjustment was made for those people with variable capacity or memory issues to help them visualise what they were choosing. We heard people at lunch asking what was for lunch as they could not remember and there was no written menu for them to see each day in the dining area. People said they liked the food and meals presented were cooked fresh and looked appetizing and plentiful. They told us "The meals are good", "We get plenty of good food", and "Food isn't bad here at all". "Food is good and it is always warm". Some people's comments were mixed and included: "I don't always know what we are having". "We always get the same drinks, but I think that is because they know what we like". "I can usually choose what I want".

People had been asked about changes to menus at a relatives meeting and some of their suggestions had been taken up but not sustained. One of the cooks told us "People change their mind what they don't want this week they will ask for next week". A relative told us that she had raised the issue of not having fresh fruit available and said that she had been told that this would happen. She said that there was only ever tinned fruit available and that fresh fruit wasn't available for snacks during the day. She told us that sometimes she brought oranges in, but didn't think staff helped or encouraged her relative to eat these as she often threw them away.

Staff told us that people could have alternatives meals if they wanted. However, an incident we observed at lunchtime demonstrated that staff were reluctant to change one person's meal: the person had on seeing other people's meals requested the same, a staff member spoke

loudly and sharply to the person in front of other people in the dining room, their response caused other people at the table and other staff to comment negatively on the person's request, their dignity was compromised and they were visibly upset by the incident. Other people had specific requests that the cooks provided for them. One person requested tomato soup for breakfast and they were given this, another person requested sausages very regularly as this was a favourite meal this showed that service staff took into account people's preferences and tried to support these.

The cooks were aware of people's specific dietary needs. Some people were at nutritional risk and the cook understood the need to fortify their meals. Some people also took food supplements. One person required a soft diet and staff assisted the person with their meal on both days of inspection. This was not consistently undertaken to a good standard. On one day we saw a staff member assisting the person with occasional words of encouragement and small talk, the staff member was later distracted by another staff member who they chatted to whilst assisting the person with their meal. On the second day the registered manager helped the person and this was undertaken well, with undivided attention given to the person and murmurs of encouragement and minor conversation.

Some people chose to eat and drink in their bedrooms, for others they had fallen into this habit and there was little attempt to encourage them down to the dining room to relieve their isolation. There were no water jugs in people's rooms, the manager said there were beakers that people could fill from the taps in their room as the water was drinkable, but some people were at risk if they chose to get up without staff support.

Staff told us drinks were given out every two hours. One person only had a small ½ beaker in their room. Another person had a large selection of drinks in their room. Some people had fluid charts in place to monitor their intake, but staff could not tell us how they monitored other people. Although staff told us they always popped their head into people's rooms to see if they were ok or wanted anything, there was a risk that some people might not be having enough to drink. The care plan for one person said 'To offer cakes, biscuits and fruit between meals'. This was not seen to be happening. The cook said that cakes were available and people could have them if they wanted, but these were not offered and there was a reliance on people remembering these were available and also asking for them. This is a breach of Regulation 14 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (d) of the health and Social Care Act (Regulated Activities) Regulations 2014.

Records showed that staff were referring people to the doctor or requesting input from other health professionals. Handover sheets informed staff where referrals needed to be made so staff coming onto shift would act upon this. However, we noted that for some people existing conditions were not well documented and did not inform staff how they needed to respond or what to look out for. One person was recorded as having seizures and dizzy spells. There was no information to inform staff what to do in the event of a seizure what it would look like, how often they occurred whether rescue medicines were needed or action to be taken in the event of the seizure lasting an amount of time. One person had not been weighed since January 2014. The records stated, "Unable to weight bear" The last attempt had been made on 1 February 2015. A staff member said that they only had household bathroom scales and the person could not stand on these scales.

The care plan for this person stated that they were at risk of developing pressure sores and that they had an air mattress and this needed to be at the correct setting for their weight. It also stated that the person could not be weighed. There was no risk assessment around this and there had been no alternative arrangements made to check the person's weight. The air mattress was set at normal pressure 100 kgs in a lying down position but without an accurate weight the setting could be too high and place the person at risk of developing pressure ulcers. Staff were applying creams and sprays to minimise the risk of this occurring.

One person was in their room and very breathless. They told us, "I don't know why they keep me alive". They told us they didn't feel very well. Their lips were dry and sore. Staff confirmed that this person was unwell and that the GP had visited. They said that they were prone to cold sores. Staff said they would pop in but there was no clear arrangement as to how often this happened to ensure the person's health was monitored appropriately and any further deterioration alerted. There was a lack of awareness as to whether some people's health needs were having a current impact on them and whether staff should be monitoring

Inadequate

Is the service effective?

this. This is a further breach of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) (a)(b)3 (b-h) of the health and Social Care Act (Regulated Activities) Regulations 2014..

We spoke with two healthcare professionals (opticians). They had made an appointment to see one person. The daughter had requested that she also attended the appointment and staff were aware of this. They tried to contact the daughter to let her know the opticians were at the service, but were unable to do so. The opticians re-arranged the appointment to give the daughter the opportunity to attend as requested.

There was positive feedback from the opticians: They said that staff always knew who they were visiting and what people's needs were and if family wanted to be present at the appointments.

Records showed that people had access to GP's, District nurses and Chiropodists, and that requests for input from health professionals when people were unwell were made in a timely way. However, the impact of conditions that people had lived with for a long time, for example epilepsy were not well understood or monitored appropriately by staff.

Inadequate

Is the service caring?

Our findings

People told us: “They are a lovely crowd in here”. “The staff are marvellous”. “There is nothing they wouldn’t do for you”. Visitors and relatives said “The staff are all very good here”. “I think they are kind”. “Overall the care is very good. I can’t fault the carers. They are very kind and considerate”.

On the days of inspection although we observed that most staff showed a kind friendly face to people, we observed some staff speaking to people in a way which was not respectful. We observed that staff spoke to people using a tone of voice which was parental, directive, and in one instance compromised the persons dignity in front of other service users when they asked about their reason for needing the toilet.

The way staff interacted with people was not consistent. Sometimes staff were relaxed and engaged with people in a patient, kind and respectful way, with occasional banter with people who clearly enjoyed this. At other times staff were not respectful or professional, for example, when we spoke with two staff about their relationship with people in the service they told us that they said they liked to have, “A laugh with people”. They spoke about one person who always asked them about what was for lunch, they spoke in derogatory terms about the person and imitated the person’s tone of voice. The staff members laughed at this and indicated to us they found it funny.

Poor practice and attitudes shown by some staff was compounded by operational practices followed by the staff for example, a notice in one person’s bedroom stated “Please do not put handbags and pads in the bottom of your wardrobe”. There was a further notice saying that this person should not struggle to do things and should ask staff for help.

A care record for a person did not take account of their emotional needs. It stated, “When the named person wants to go to her room – she comes over all unwell and finds it difficult to wait when staff are busy”.

Staff did not always respect people’s privacy and dignity. We observed a staff member came into the lounge and said quietly to one person “Is it just a wee?” The person said “No”, to which the member of staff loudly replied “Oh no not again”. The person was taken to the toilet which opened directly into the lounge. The member of staff sat outside whilst the person was in the toilet respectful of their privacy but when she checked to see if the person was finished she left the door open slightly and it was possible to observe the people in the toilet. She could be overheard loudly saying, “Have you finished yet” “Stand up straight”. “Let me help with your trousers”.

Because the toilet was situated in the lounge everyone sitting in the room could either hear or see what was happening in the toilet. One lady later told us that she didn’t use that toilet, “Because everyone knows where you are going”.

One member of staff constantly used ‘familiar’ terms such as, “Lovie”, “Poppet” and “Darling”. Other inappropriate comments included: “Do you want a bikkit?” when offering out biscuits during the morning. Also “Wake up boys , I have biscuits for you, take one if you want one”, and “Good girl” when administering eye drops to another person.

At lunchtime on the second day of inspection we observed an incident that demonstrated a lack of awareness amongst the staff present including the manager that their practice was poor and impacted on maintaining the dignity of people being supported. A person with variable capacity and memory issues decided they wanted a different meal to the one selected earlier that morning, they said “Oh I wish I could have had sausages”. The member of staff who had given out the meals said, “Oh alright. Oh sweetie” and then walked off. We heard the member of staff mentioning this in the kitchen. Another member of staff came through to the dining room and said very loudly across the room “You should have said earlier when you were asked”. The person said, “I can’t remember being asked”. The member of staff repeated, loudly “You have should have asked for sausages before”.

This resulted in two members of staff and three other people all becoming involved in the conversation. Although the person was eventually provided with an alternative meal she had become visibly upset by the incident.

The failure to ensure that people are treated with consideration and respect is a breach of Regulation 17 (1) (a) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 (1) of the health and Social Care Act (Regulated Activities) Regulations 2014..

Inadequate

Is the service caring?

We observed that some staff sought people's consent before support was given. "do you mind if put a tabard on you so you don't get any food down your clothes". "Are you ready to move to a more comfortable chair?"

Staff were able to support people with less complex needs but lacked an understanding of how to support people whose behaviour challenged them or with whom they could not communicate. Observations showed that interactions with people with these needs were limited outside of times when personal care or meal tasks were being undertaken.

Care plans did not all have personal histories although this was something that the registered manager was working on with relatives to provide this background information. Staff listened to people but did not have much time for this. Staff told us they missed not having time for people. A staff presence was lacking for most people during the day other than when they needed support around personal care tasks or with their meals, people told us that, "It can be a very long day".

One person living with dementia who needed constant monitoring by staff, was not always tolerated by other people in the service who found the persons behaviour challenging. Staff handled this by bringing the person into an area where staff were but otherwise engaged, For example on the first day of inspection the person was brought to the dining table at approximately 12 noon the person was sat at the dinner table on their own from 12-12:40 when lunch was served, staff interactions with the person were limited, .they were not provided with a drink or given anything meaningful to do.

When lunch was served a staff member appeared and was seen to explain kindly to the person what was for dinner and asking if they liked that. Initial assistance with the meal was good explaining the person was eating a piece of broccoli, and asking them to sit up so they could take their medicines, but as the staff member became distracted with talking to another staff member their engagement with the person became less although they continued to assist them with eating their meal.

Some people were more mobile and could move around the service as they pleased. One person told us they could spend their time where they wanted. Other people had to rely on staff and were unable to walk around. Some people's movements were restricted by other people who told them to sit down and wait for staff.

Staff were clear about confidentiality of people's information and respected this. People were given privacy when personal care was being delivered in their bedrooms or bathrooms, or visitors came to see them, but there was nowhere private other than their bedrooms for people to go. People's doors were kept shut. A relative and a visitor told us they could visit whenever they wanted to. Three people said they could have visitors when they wanted.

Inadequate

Is the service responsive?

Our findings

People did not know about their care plans. One person told us, "I don't know what a care plan is, but I am not interested, so long as the girls know what they are doing". A relative said they knew that a new care plan had been written and they had been involved. However, they had been promised by the registered manager that they could see the care plan but, "That was in November and I haven't seen it yet".

At our last inspection in September 2014, care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. People were at risk of not receiving the care they required because accurate records were not maintained. This was a breach of regulation 20. At this inspection the provider had not fully completed their action plan which told us all care plans would have been reviewed and updated by the end of January 2015 and would be in the new format.

One care plan viewed had not been updated. The moving and handling risk assessment had not been reviewed since 30 June 2012. The care needs assessment had last been completed on 9 May 2014 by the registered manager. There was no actual care plan, no life history or personal information. The manager stated that she was in the process of completing this care plan and was able to show evidence that it had been started, but there was no evidence that staff were supporting the person in the manner they preferred or that they were receiving the care and support they required. This is a continued breach of Regulation 20 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager had completed ten out of twelve care plans, and these had been updated in consultation with people and their relatives. The new updated care plans were individualised and provided staff with information about how people wanted to be supported. We saw examples of support from staff that showed they were not adhering to the updated care plans, and there remained gaps in some care plans of important information that could inform staff about how people's conditions impacted, on them and how staff were to support this, for example the needs of people with epilepsy.

One person we sat with had the radio on so loud in their room that we could not be heard, they asked if we would turn this down. The radio was on radio 2 playing a variety of 'pop' music, we asked the person if they enjoyed listening to music and was this a favourite radio station, they told us that, "They (staff) just put it on and leave it like that, I would prefer to listen to a nice symphony or something like that". Later when we viewed the persons new care plan it was clear that the person was a fan of radio 4 and preferred to listen to classical music. On the second day of our inspection this person was unwell and spent the day in their room. We visited them in the morning. There was no TV or radio on, there were books in the room but they were out of reach. Their care plan said that staff should support the person to socialise, chat and feel valued. There was no evidence that this was happening during our visit. There was a record of concerns noted by the family that they felt this person was isolated in their room and they wanted them to become more involved and spend more time in the lounge. There was some evidence that staff had made some attempt to do this and that when they had the person had wanted to stay in the lounge for longer. Support to enable the person to integrate more and become less isolated was not consistent. This is a further breach of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) (a) (b) (3)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

One person living with dementia sometimes refused personal care. The care plan made clear that staff should manage this sensitively, retreating and offering the support again at a slightly later time. An experienced staff member told us that if this person needed to be washed and changed they would be washed and changed whether they liked it or not emphasising that there were always two staff and they could manage the situation. This was clearly in direct contradiction to the persons care plan and was a breach of regulation 11 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 (1)(2)(4)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a lack of activities people told us that "it's a long day". They told us that staff did not really have much to do with them during the day and although we noted a few external entertainments had been brought in, the planned development of the activities programme and the role of

Inadequate

Is the service responsive?

activities co-ordinator had not progressed. The Activities co-coordinator told us that "they are not really interested in doing anything themselves like making things they prefer to sit and watch entertainment".

A relative said that she didn't think, "There was much to do as everyone is usually just sitting in the lounge". Another relative said, "There isn't much in the way of activities. Mum sometimes gets her nails done and I think the vicar visits because he attended a meeting. I think they occasionally have singers, but generally there is very little stimulation".

Throughout the visit there were no observed activities. During the morning the TV was on in the garden lounge and this was playing a radio channel. Most people were sitting and staring into space. One person was reading a newspaper; they told us this was yesterday's paper. When asked if they had todays, they said they might get it later.

Another person told us that they preferred to spend all their time in their room. They had access to their preferred music and told us they were happy staying in their room. They said they could change the music and watch what they wanted on TV.

There was a complaints procedure in each person's file. Most people we spoke with didn't know about this and had not looked in their file. There was a notice board outside the garden room and the complaints procedure was on display. It was in small print and not easily readable. One person told us they would always speak to the manager who was, "Very good". A relative told us that at a relatives meeting they had raised 13 points at this meeting, this included issues of concern regarding the lack of baths being offered which they thought had now improved slightly. The poor quality of bedding and linen and towels, although they thought new ones had now been purchased, and a lack of fresh fruit for people in the service.

The relative couldn't remember the other issues they had raised but overall felt that the provider was slow to respond and, "Meant well and has good intentions but doesn't follow through with promises".

The complaints log recorded one complaint from a relative that had been investigated by the manager but not yet resolved. We were aware that other complaints had been raised in respect of laundry, medicines management, bathing, use of agency staff and activities. Breaches highlighted as a result of this inspection would indicate there had been limited learning from these concerns.

Concerns raised by people and relatives were not routinely recorded within the complaints log. In the daily notes for one person there was a record that they had not received their medicine when they should have, relatives had complained about this but this had not been recorded in the complaints log and was not counted as a complaint.

Daily notes also recorded relatives concerns about the isolation of their relative and a desire for them to move to a ground floor room. The manager had told them that another resident was a higher priority for this room because they were a falls risk, but during our inspection relatives of a prospective new resident had been shown the same ground floor room. From the records it was not clear how the staff were alleviating the families concerns of listening to what they had to say, the family remained unhappy and the situation had not been handled well. This is a breach of regulation 19 of the HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 (1)(2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the previous inspection in September 2014, we identified breaches of five regulations. At that time we issued compliance actions and gave the provider and registered manager time to make improvements to the care and welfare of people and the monitoring of the quality of service provision. The provider sent us action plans stating how they would address the areas of concern and meet the requirements of the regulations. They told us they would meet the requirements of some breaches by the end of November 2014, others by December 2014 and the last one by the end of January 2015.

At this inspection although we found the provider had made some progress in all the areas of breach, this was not sufficient to meet the requirements of the regulations. In addition this inspection has highlighted nine further breaches of regulations. This demonstrated that the service was not well led. Concerns which had been highlighted to the management were not addressed adequately and the impact this had on people living at the service had not been considered, placing them at risk of receiving inadequate and poor standards of care.

The registered manager had made an assessment of the service upon taking up post and had developed an action plan of improvements she wanted to make. This included a handover sheet and also improvements to care records. Plans to introduce these improvements had been hampered by initial resistance from staff who were unused to the level of recording and involvement documenting people's care needs than they had previously. As a consequence some staff had decided to leave, there was also a high level of sickness and this had created staff shortages and the need for agency cover on some shifts. One staff member we spoke with said that having initially been resistant to the introduction of the handover sheet she now recognised its value and felt this was a great improvement to ensure information was handed over accurately between shifts.

The staff team did not feel well supported through the changes the registered manager was trying to make and no longer was felt there a sense of team work. Staff meetings were held but staff did not feel these were arranged for the benefit of staff or a forum where they could raise issues important to them. Individually staff commented that they had found the registered manager supportive to them regarding their own private issues, although some commented that she was sharp with them at times.

There was a lack of a clear staffing structure in the absence of the registered manager and senior carer in which staff knew their responsibilities and lines of accountability. We found when we visited on our second day of inspection, that staff were unclear about who should be responsible for us whilst we were there, and showed an unwillingness to take responsibility for decisions that might need to be made. Staff rotas did not make clear who should be shift lead in the absence of senior staff.

The registered manager had implemented a robust medicine audit and also a catering audit and we could see where shortfalls were being highlighted but actions taken to address these were unclear and other audits we had requested previously were not in place. For example although the cleaner had a clear understanding of what constituted a room clean this was not documented so the manager was unable to audit whether all areas of cleaning had been conducted on a daily, weekly or monthly basis, and in the absence of the cleaner no one covering that post would know what had to be done each day or at other intervals.

The provider carried out regular visits to the service and completed visit reports. These were not effective. There was no evidence that these were used to drive improvement given the number of breaches of regulations we found, or that they provided a means of assuring the provider about service quality across the whole service and that identified actions were carried forward and dealt with. This is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1)(2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager planned to facilitate resident meetings every three months and one had already been held. There had also been a relatives meeting in October 2014. Staff said they were provided with minutes from resident's meetings to read. People and their relatives were asked to give their views about the service and relatives

Inadequate

Is the service well-led?

meeting and resident meetings had been reintroduced, we requested a copy of the most recent analysis of questionnaires but this was not provided during or subsequent to the inspection.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Service users were not protected against the risks associated with unsafe or unsuitable premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The provider had not ensured that equipment was available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs. Regulation 16 (2). Equipment had not been supplied to ensure people's safety, maximise their independence and meet their preferences.