Barchester Healthcare Homes Limited

Werrington lodge

Inspection Report

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Contents

Summary of findings

Overall summary

Werrington Lodge is care home providing accommodation and nursing care for up to 82 adults.

There were 79 people living there when we visited. The care home provides a service for people with physical nursing needs and for people living with mental health or dementia. The home comprises of two units, one for older people who require nursing and another for people who live with a dementia related illness. There is a manager registered at the service.

During the course of this two day inspection we found significant concerns about the care people received in the home and we took immediate action to safeguard them. This included passing information to the Local Authority for them to look at under their safeguarding vulnerable adults procedures. We also met with health professionals who were funding people's care and with the registered person to escalate our concerns and ask for immediate action to be taken. The registered person has told us what actions they will be taking to improve the service and the steps they will be taking to make sure people receive the care they should. The service is being monitored closely by us and Commissioners.

We found the home was not clean and people were at risk of acquiring a health associated infection. People were not protected from the risk of abuse and their rights under the Mental Capacity Act 2005 were not taken into account.

People were not protected from the risks of developing pressure ulcers or from falls. Staff were not monitoring or supporting people when they were nutritionally at risk and people were not given appropriate help with drinks.

We saw a lack of care and compassion for people with staff ignoring their shouts for help and assistance. Staff did not show respect for people in relation to their privacy and dignity.

There was a lack of stimulation offered to people and there were no effective systems in place to support people to have a say in how they were cared for.

We saw a lack of leadership and direction given to staff and although there were systems in place to monitor the quality of the service, these were not effective and action had not been taken to address failings identified in the home.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. (The deprivation of liberty safeguards is a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice.) The Mental Capacity Act (MCA) 2005 is an act introduced to protect people who lack capacity to make certain decisions because of illness or disability.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. We found the location may not be meeting the requirements of the Deprivation of Liberty Safeguards.

We found there were a number of breaches in the Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2010 at Werrington Lodge and you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the home was not clean and people were not protected from the risks of the spread of infection. The home smelled of urine in places and we found dirty furniture and carpets in communal areas and one bedroom.

People were not protected from abuse as the systems in place to check that staff were safe to work with vulnerable adults were not effective. People were also placed at risk of abuse from other people living in the home and from a lack of investigations and referrals when people acquired injuries or bruising.

There was a lack of knowledge of the Mental Capacity Act 2005 from the manager and staff employed at the home. This led to a lack of assessments in place to ensure people were being involved in decisions about their care and treatment. We found the location may not be meeting the requirements of the Deprivation of Liberty Safeguards.

Are services effective?

People were not being supported to use an advocate to speak up for them and people were not involved in planning or reviewing their care and treatment.

We found that people were not receiving care and support which met their needs and supported them to stay healthy. People were left in bed for long periods of time during the day and we found some of them had been incontinent of urine and were left lying in beds which were wet.

People were not being protected against the risks of developing a pressure ulcer or from the risks of falls and injuries from falls. There had been no investigation into why two people had fallen frequently to see if the falls could be minimised or if equipment could be put in place to minimise the injuries they had sustained.

We saw that some people had lost weight and staff had not given them support to maintain their nutrition. We had concerns about the hydration of some people who spent most of their day in bed and who relied on staff to give them a drink. There were no records to show when people had last received a drink and we saw some people who had very dry mouths which indicated they had not being given enough to drink.

Summary of findings

Are services caring?

We received some positive comments about the staff and the care people received. One relative said, “The carers do their best.” One person living in the home said, “Very nice and helpful.”

However our observations did not support what these few people told us. We saw examples of a lack of care and compassion for people, particularly people who were in bed. When we pointed out failings in care to the nurses, they showed a lack of concern for what we were telling them. We found people who had been left in bed until the afternoon, from the night before and there was no evidence they had received any personal care from staff.

We heard people calling out for help from staff and staff ignored them and walked past the people who relied on their care and support. We found people left lying in bed, wet with urine and with their curtains still closed from the night before. We found some staff did not have any knowledge of the people they were supporting. We saw that staff were mainly task orientated and that they rarely spoke with people whilst delivering care and support. Any communication was mainly of a commanding nature such as, “Open your mouth” or “Eat your food.”

Staff were not respectful of people’s privacy and dignity and we had to ask for people to be assisted to be covered up when they had exposed naked parts of their body. The bedrooms and care plans of people were identified by numbers and not names, which was not dignified. People’s confidential care files were left unlocked and freely available for other people to look at.

Are services responsive to people’s needs?

We found that people were not given choices about their care and treatment in line with their best interests and care plans held very little information about the preferences people had in relation to their care. There were no effective systems in place to enable people to give their views on the service on a regular basis.

There was one activities organiser employed to provide activities and stimulation to the 79 people living in the home and we found there was a lack of stimulation and activities tailored to individual needs and preferences. People left in bed were at risk of social isolation.

There was not an effective system for responding to complaints and any complaints recorded did not give sufficient detail to show how the complaint had been investigated and responded to. This meant there was no evidence to show the complaints had been responded to appropriately and action taken to address them.

Summary of findings

Are services well-led?

We observed on the first day of our inspection that there were enough staff on duty to meet the needs of people who used the service. However these staff lacked direction and did not respond to the needs of people. On the second day of our inspection there were less staff evident in the home and staff told us this was due to sickness. There were not enough staff to meet the needs of people on the second day of our visit and on a few occasions we struggled to find staff to assist people when they were ringing their call bell for assistance. This resulted in people having to wait for staff to give them support when they needed it. On both days we needed to intervene on many occasions and ask staff to provide care and support to people.

We saw evidence that the provider had systems in place to assess the quality of the service provided to people living in the home. However we found these were not effective. The provider had identified concerns in December 2013 such as the ones we found during this inspection but no action had been taken to ensure the care and safety of people living in the home had improved.

There was a general lack of direction and leadership in the home during our inspection with the manager and the nurses not being visible or leading staff in care delivery.

Where people were regularly having accidents or falls, there was no investigation into this to see if there could be learning and steps taken to minimise the risk of further falls or accidents. This was also the case when people were found to have bruising or injuries from an 'unknown cause.' This meant the service was not learning from incidents or accidents.

Summary of findings

What people who use the service and those that matter to them say

We found that there were quite contradictory accounts of this service from the people we spoke with and from what we saw and found. We received some positive feedback about the staff with comments such as, “Very nice and helpful” and “It’s a care home and they care.” People commented positively on the food saying the food was “Alright”, and some said it was, “Very nice”.

However, during our two day inspection we observed care and support given to people and found significant concerns about how people were cared for.

We saw that staff rarely initiated any communication with people living in the home. Even whilst assisting people with a meal staff were disinterested choosing to look around the room or at the television rather than engage with the person they were supporting.

Two people and one visitor we spoke with told they had concerns about items going missing from bedrooms. One person said that bedrooms could not be locked. Another person told us, “Someone has taken my watch and other jewellery from my room.”

A visitor referred to personal items going missing such as, clothing and jewellery bangles. They said, “That’s what I don’t like – I don’t like that sort of thing.” Two visitors also raised concerns about their relative who had sustained bruising on their hands. They were unsure where the bruising had come from. We heard one visitor say to their relative, “You have been in here for over a week and you haven’t had a shower.”

We spoke with one person who was in bed and asked them why they had not eaten the meal staff had taken to them and they said, “I can’t eat it laying down can I.” This person needed help to sit up in bed and we had to ask staff to assist the person to sit up as they had not responded to the person ringing their call bell. One person who was still in bed at 12 noon told us, “I have been waiting for hours for staff to come and help me get up.”

We spoke with people about what they knew about making a complaint and some people told us they did not know how to make a complaint. One person said, "I don't know if there's a complaints form or not." Another person said, "There are slip-ups sometimes, but they're usually put right.”

Werrington lodge

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Before our inspection we reviewed the information we held about the home. We examined notifications received by the Care Quality Commission and we contacted the commissioners of the service to obtain their views on the service and how it was currently being run.

We visited the home on 8 and 12 May 2014. We spent time observing care and support in the lounge areas and dining rooms. Due to the complex needs of some people living at Werrington Lodge they were unable to talk with us. We therefore also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at all communal areas of the building including the kitchen, bathroom, activity room and some people's bedrooms. We also looked at records, which included people's care records and records relating to the management of the home.

The inspection team consisted of a lead inspector, two further inspectors, a specialist nursing advisor and an expert by experience who had experience of older people's services.

Over the two days we visited we looked at the care records relating to 15 of the 79 people living at Werrington Lodge. We spoke to the manager of the service, 14 people living in the home, five trained nurses and 13 other staff on duty. We last inspected the service in December 2013 and the service was compliant with the regulations we assessed them against.

Are services safe?

Our findings

We had concerns about the cleanliness of the service. We saw people were sitting in dirty and stained armchairs. There were dirty wheelchairs and most areas of the home smelled of urine. Cushions on specialist chairs that were used to help people move around the home were dirty and had food debris on them. There were pressure relieving cushions which were torn and dirty and would pose a risk of the spread of infection through body fluids. The carpets in communal areas, particularly in the lounge on in an area of the home called 'memory lane' were dirty, stained and were covered in food which had been trodden in. We found one bedroom which was also dirty and smelled of urine. This meant people were not being protected from the risks of the spread of infection.

This meant there had been a breach of the relevant legal Regulation (Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010) and the action we have asked the provider to take can be found at the back of this report.

We looked at the personal files for seven members of staff to check that the provider had robust recruitment processes in place. We found that six of them contained a suitable application form, disclosure barring checks had been obtained before staff had commenced employment to ensure that they were suitable to work with vulnerable adults.

However, when we reviewed the seventh file we found that this member of staff had not been appropriately assessed to make sure they were safe to work with vulnerable adults. Although checks had been undertaken prior to the person commencing employment, there was no record of how an unacceptable reference from a previous employer had been explored. This meant that the provider had not operated effective recruitment procedures in relation to a member of staff who did not have acceptable references and this may have placed people at risk.

This meant there had been a breach of the relevant legal Regulation (Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010) and the action we have asked the provider to take can be found at the back of this report.

All staff had completed an induction, which covered all the basic skills needed for their role and included how to move people safely; medication; food hygiene; first aid and protecting people from harm. Staff then spent time 'shadowing' an experienced member of the team before they worked alone. One member of staff who had been recently recruited told us: "I had a good induction to my job. I worked with another member of the team for the first few days."

This meant staff were given the information they needed on how to care for people safely, when they first commenced employment.

People who used the service may not be protected from the risk of abuse because the provider had not taken all reasonable steps to identify the possibility of abuse and prevent abuse from happening. The people we spoke with told us they felt safe from harm and staff had received training in how to recognise and respond to abuse. However we found that where people had sustained injuries and the cause was unknown, these were not investigated or referred to the Local Authority safeguarding vulnerable adult's team, in line with policies and procedures. For example we saw records which showed two people, who were fully reliant on staff due to them not being able to move independently, had sustained cuts and bruising to their hands and arms. These injuries had not been investigated and referrals had not been made to the safeguarding vulnerable adult's team. This meant there were not any investigations into how bruising or injuries were sustained and people were left at risk of abuse.

Two people and one visitor we spoke with told us they had concerns about items going missing from bedrooms. One person told us that the bedrooms could not be locked. Another person told us, "Someone has taken my watch and other jewellery from my room." A visitor referred to personal items going missing such as, clothing and jewellery bangles. They said, "That's what I don't like – I don't like that sort of thing." Two visitors also raised concerns about their relative who had sustained bruising on their hands. They were unsure where the bruising had come from. There were no records to show that any of these incidents had been investigated by the manager.

One person living in the home had been assessed as needing constant supervision from staff due to the risks they posed to other people. We observed a staff member letting this person go out of their sight on different occasions. At one point we asked the staff member where the person was and they told us the person was in their

Are services safe?

bedroom and they were watching the bedroom door for when they came out. However the person was not in their bedroom, they were in the dining room with other people living in the home. On another occasion the person was in the dining room and was not visible to the staff member. The staff member told us, "It doesn't matter if I can't see them in the dining room." This meant staff were placing other people at risk of harm from this person by failing to follow the person's care plan, which stated they should be monitored at all times.

This meant there had been a breach of the relevant legal Regulation (Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

We looked at the care records in relation to mental capacity assessments for six people and found that the Mental Capacity Act (MCA) 2005 was not being adhered to. This is an Act introduced to protect people who lack capacity to make certain decisions because of illness or disability. The manager and staff we spoke with in relation to the MCA did not have had a good understanding of the MCA and how it should be applied. There had been no assessments carried out to assess if people had the capacity to make decisions for themselves. There had been training given to staff in relation to the MCA, however staff we spoke with had a poor understanding of the Act and said that the manager had any assessments that had been completed in their office. However when we spoke with the manager we found that they also had a poor understanding of the MCA. This meant staff did not have the information they needed to make decisions for people who lacked capacity, based on what was in the person's best interests.

Some people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in place. We looked at the records of six people who had one of these forms and only one of them was completed properly. There was information missing from the forms such as why the decision had not been discussed with the person. We saw that staff had recorded that five of these people lacked the capacity to understand the decision. One person who lacked the capacity to make this decision did not have any family to get involved in the decision. Staff had not involved an external advocate to speak up for this person and support them to make decisions for themselves. A nurse employed by the home had signed off a DNACPR for this person without receiving input from an Independent Mental Capacity Advocates advocate, in line with the MCA code of practice. There had been no formal assessment completed to see if this decision was in the person's best interests. This meant the wishes of people may not be adhered to at the end of their life.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. The manager told us there was no one living in the home currently that had one of these safeguards in place. However, we found three people who had received constant supervision from staff throughout the day and who were restricted from leaving the unit or the home. The manager had not sought advice on whether these three people should be subject to a DoLS authorisation prior to the new court ruling. We were told by staff that one person was 'restrained' in an armchair to prevent them getting up freely due to them keep falling. We also saw people who lacked mental capacity who were left in bed by staff and were restricted from leaving the bed by the use of bed rails. Bed rails can be seen as a type of restraint if they prevent people from leaving their beds. None of this had been considered under the DoL Safeguards. We found the location may not be meeting the requirements of the Deprivation of Liberty Safeguards.

This meant there had been a breach of the relevant legal Regulation (Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

Are services effective?

(for example, treatment is effective)

Our findings

None of the people we spoke with knew about their care plan. There was no evidence in the care plans that people were supported to get involved in the development or the reviews of their plan. There were no records to show if any meetings had taken place with people or their significant others to try and involve them in planning their care. This meant people were not being involved in making decisions about their care and treatment.

The manager told us that no-one who lived in the home was currently using an advocate They told us there was information on how people could access an advocate in the reception. We could not find this information; there was information on getting advice on care fees but not how to access an advocate. We saw one person living in the home who would benefit from having an advocate as they did not have any family to speak up for them and they were unable to speak up for themselves. This had not been recognised by the manager or staff. Advocates are trained professionals who support, enable and empower people to speak up. This meant people may not be aware of advocacy services which are available to them.

This meant there had been a breach of the relevant legal Regulation (Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

We found conflicting evidence across the home in relation to how people's health care needs were assessed, planned for and delivered. Records showed that people had access to health care professionals such as GPs, chiropodists, opticians and dentists on a regular basis. However we found no evidence that the people whose care records we looked at had been referred to see a physiotherapist when their mobility declined. Some people spent a great deal of their day and night in bed and this could be a factor for a decrease in mobility. There was no evidence staff had sought advice on whether chair or bed exercises may support these people to maintain greater independence or ease their joints.

Where a risk had been identified to people such as being at risk of falling or developing a pressure ulcer, a care plan had been put in place for the assessed risks, informing staff how to support people and minimise the risks. However we found staff were not following these in a consistent way.

We saw from the records of three people that they had been assessed as not being able to use a call bell to summon help from staff. Staff had recorded in care plans that all three people should spend the day in communal areas so that they could be monitored or supervised by staff. We found that the care we observed being provided conflicted with what was in the care plan and that all three people were left in bed until early afternoon until we asked for them to be assisted out of bed.

We had concerns about the amount of people who were left in bed for most or all of the day. There was no clear rationale for this other than the manager telling us that it was 'individual choice' or 'they are confined to bed.' On the second day of our inspection we again had the same concerns and we commenced a tour of the home at 11am. We found there were 28 people still in bed and that three of these people had been incontinent and had been left lying in unclean bedding.

The records of six of these people showed they were at 'high risk' of developing pressure ulcers. All six had equipment in place to help to reduce the risk of them developing a pressure sore. However when we asked staff if they kept records of when people were being supported to change position, in order to minimise the risk of pressure ulcers developing, we were told by two staff that people were only supported to change position if they actually had a pressure ulcer. The National Institute for Health and Clinical Excellence (NICE) CG29 "Pressure ulcers: The management of pressure ulcers in primary and secondary care" dated September 2005 states that one of the best ways of preventing a pressure ulcer is to reduce or relieve pressure on areas that are vulnerable to pressure ulcers (for example, bony parts of the body). This is done by moving around and changing position as much as possible. This meant staff had placed people at risk of developing a pressure ulcer.

People were not protected from falls or the risk of falls. We saw that one person had sustained significant bruising and injuries and the manager told us that this was due to the person falling on a regular basis. They told us, "[The person] falls all the time and we can't stop this other than

Are services effective?

(for example, treatment is effective)

to restrain him, which we are not allowed to do." We looked at the person's care plan and we saw there was no information telling staff what they could do to try and prevent the person falling or how the risk of injury could be reduced if the person did fall, such as the use of a 'crash mat.'

Another person had fallen 14 times in the five months prior to our visit. Staff had recorded that the person was at risk of falls due to an unsteady gait and that the person should wear non slip socks as a step to minimise the risk of falling. However, we noted that the person was wearing ordinary socks and no shoes, which would increase their risk of slipping on the laminate flooring. We observed the person was very unsteady on their feet when they mobilised and twice had to intervene and ask staff to assist them as staff had not noticed the person was mobilising. We saw records of the falls this person had sustained and there had not been any learning from them to take steps to minimise the risk of further falls. There was no evidence of advice being sought from health professionals such as the falls prevention team.

Care plans for people were not clear in relation to their current needs. Each plan contained an assessment of the person's needs such as mobility and then an evaluation was added at a later date. This meant that as people's needs changed, the initial plan was not updated but was added to further down the page. This would be confusing for a new member of staff or the agency staff employed by the manager to ascertain the current needs of people. For example, we read that one person was independently mobile and able to move around the home without assistance. We saw from observations this person needed the help of two staff and equipment to transfer them from chair to chair. We checked the plan again and saw that the person's current needs regarding mobility was recorded in the evaluation but the initial plan of care had not been updated. This was the case in all of the plans we saw.

People's medical histories had been recorded in care plans. However where people had an identified medical need such as a heart disease, glaucoma, diabetes, anaemia and other health needs, there were no care plans in place giving staff information on how to monitor and respond to any change or deterioration of these health conditions.

This meant there had been a breach of the relevant legal Regulation (Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

The people who were in bed for the duration of our visits did not have access to a drink as they were unable to get out of bed independently and drinks were not within their reach. Staff had not recorded when they had given people who stayed in bed a drink. We found several people who had very dry lips and there was no evidence to show when they were last given a drink. One person, who staff told us was on end of life care, was in bed and we saw their mouth was very dry. Staff told us they did not have a record of when they last gave this person a drink or any mouth care. This meant people were being placed at risk of de-hydration.

We saw one person who was in bed just before mid-day and their breakfast was still in front of them. The food and drink were cold and untouched. We looked at this persons care plan and saw staff had recorded the person needed prompting with food as they had lost weight. Records showed they had lost 3kg in the last 12 weeks and staff had recorded, 'Still losing weight. Requires a lot of encouragement and prompting to finish meals.' We observed this person being given lunch and they did not eat their food which was removed without any prompting from staff. We asked staff if they had kept records of what this person had been eating and drinking and they told us they had not. A further person, who was unable to move independently, or communicate with staff, was still in bed at 12.35pm and there were no records to show when staff had last given this person anything to eat or drink. This meant these two people had not been supported with their nutrition and so were placed at risk of weight loss and ill health.

Two other people needed support with their nutrition due to weight loss and we saw this support was not being given. One person could not easily reach their meal at lunchtime as the table was too far away and staff did not notice this. They ate very little and then gave up trying to reach. Staff removed the meal without prompting the person to eat more. The person was then given their dessert, which was a milk pudding, and they struggled to

Are services effective?

(for example, treatment is effective)

eat this as the pudding was too far away and kept falling off the spoon. It was recorded within another person's care plan that they should be weighed weekly due to the risk of weight loss but staff were not doing this.

We saw from the records of one person that they had been assessed by staff as being at 'high risk' of choking. On the first day of our inspection we saw staff give this person a pureed diet and they said this was because of the risk of them choking on food. On the second day of our inspection the person was given a normal diet and when we questioned staff about this they told us the person was, 'on a normal diet as [the person] can chew ok.' The person was at high risk of choking and so should have been given a soft diet. This meant staff did not know about the risks to this person and so were placing them at risk of choking.

This meant there had been a breach of the relevant legal Regulation (Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

Are services caring?

Our findings

We received some positive comments about the staff and the care people received. One relative said, "The carers do their best." One person living in the home said, "Very nice and helpful." Another said, "It's a care home and they care."

However our observations were in direct conflict to these comments. We saw examples of a lack of care and compassion for people, particularly those who were in bed. For example, we found a person who was in a bed which was soaked with urine and when we questioned the nurse about this, they were not concerned and said it was because, "[The person] does drink a lot."

We found one person who was still in bed at 12.35pm and there was no evidence that they had received any personal care from staff that day. Their bedroom was in darkness with the curtains still closed and they were wide awake. This person could not move by themselves and could not communicate. We saw they were flat on their back and still had medication in their mouth from the morning medication round. When we spoke to the registered nurse they spoke about this person in a matter-of-fact way that demonstrated little compassion or concern.

We observed a nurse redress a wound on a person's leg. The nurse told us they did not know how the wound had occurred and we saw the dressing covering the wound was not big enough to cover it fully. The nurse rubbed the wound, which was not necessary as the wound was clean and this made the person yell out.

We heard a further person shouting for help from staff and we saw different staff ignore this and walk past the person's bedroom. We went and spoke with the person and they said they wanted to get out of bed. We observed this person was lying in a bed which was soaked with urine. A third person was shouting for help in a communal area and we again saw several staff walk past and ignore the shouts for help. We spoke with this person and they told us, "Please, I want to go to the toilet." We saw one person had used their call alarm to summon staff for assistance and despite there being three staff in the immediate area, none of them responded to the person until we asked them to.

Two other people were still in bed in the afternoon and we found they were both lying in urine soaked beds and one was banging on the side of the bed rails to get staff attention. They did not have access to a call bell and there were no records to show when staff last checked on these people or gave them any personal care. We had to intervene on these and other occasions and instruct staff to assist people who needed help and support.

We saw there were three people who had designated staff to stay with them all day on a one-to-one basis. This had been funded due to the high dependency needs of these people. We observed and spoke with the staff who were spending time with the three people and we found that two of the staff were agency staff had not been told anything about the preferences or needs of the two people they were monitoring. The impact of this was that neither of the staff engaged with the two people they were spending time with or tried to support them to get involved in any meaningful activity. They spent the day either sitting quietly with the person of following them around. On the second day of our inspection we saw that one of the people had deteriorated significantly in their health. However the staff spending time doing one-to-one supervision with them told us they didn't know the person and so was unaware of any deterioration. We asked the nurse to call the GP to check the health of this person. This meant the lack of knowledge staff had of people's needs and preferences had an impact on their health and wellbeing.

There was an inconsistency in relation to people's end of life care. We saw one person had a plan in place which would direct staff to make sure the person would be pain free and comfortable at the end of their life. However another person did not have any plans in place for this despite staff telling us the person was nearing the end of their life. This meant there was a risk that this person would not end their life comfortably and pain free.

We saw a member of staff pull one person up off the floor with their arms. The member of staff could not give an explanation of why they had not used lifting equipment. This placed the person at risk of acquiring an injury.

We observed care being provided in the main lounge on the memory unit for one hour on the first day of our inspection. We concentrated our observation on the interactions between staff and four of the people who were in the lounge. Interactions between staff and these four people were minimal. We saw that the nurse administered medication with a kind manner, however other interactions between staff and people were negative and lacked warmth and compassion. We saw a staff member telling a

Are services caring?

person to, "sit down!" Another person's mouth was wiped roughly without explanation. We saw a staff member stood over a person to support them to drink and persisted in giving a drink to them when they clearly did not want it.

We did see one positive interaction when one carer said, 'Happy Birthday 'to a person living in the home and told them it was their Birthday and reminded them that their relative had visited.

This meant there had been a breach of the relevant legal Regulation (Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

Staff were mainly task orientated and rarely spoke with people whilst delivering care and support. During the mealtimes we observed there was almost silence in the dining areas and on one occasion when a person spoke, a member of staff told them they should not speak at the table. There was a lack of respect for people living in the home from staff with the only communication given in the form of orders such as, "Open your mouth" or "Eat your food." We heard staff discussing the care needs of people living in the home, in front of others. Staff rushed people to wake up so they could give them their meal and we saw the cleaner hovering and spraying cleaning liquid round people's feet as they were sleeping in the lounge.

Throughout our inspection, we had concerns about the lack of privacy and dignity afforded to people. We saw many examples of people in bed in their nightwear with the bedroom door wide open. Some people were exposing bare flesh and this went unaddressed by staff and the manager until we asked for people to be covered up. Other people living in the home and visitors were walking around the home and were able to see people's exposed bodies. We saw two examples of people being assisted by staff with personal care and staff had left the toilet/bedroom door open, exposing people's nakedness. We saw a person partially undress in a communal area in front of other people living in the home and staff did not notice this. This meant staff did not recognise or respond to people's privacy and dignity.

We observed that most people living in the home did not have their name on their bedroom door and instead just had a number. The care plans were also identified by room numbers and not names. When we asked staff about the care of people, we were continually asked, "What room are they in?" This was not dignified and could lead to staff failing to treat people as individuals.

This meant there had been a breach of the relevant legal Regulation (Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

Care plans on one unit of the home were kept in an unlocked cupboard in the lounge/dining area with confidential information relating to people living in the home freely available for anybody to look at. We also saw many occasions where confidential care records were left on tables in the lounges and the dining area. This meant people could not be assured information about them was being treated confidentially.

This meant there had been a breach of the relevant legal Regulation (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

There was an annual satisfaction survey carried out by the provider to get people's views on the service. This had last been carried out in October 2013. The manager told us that people failed to attend meetings arranged for people living in the home and their relatives. They told us they advertised the meetings by placing posters around the home. The manager told us there was a meeting planned for the week following our visit, however we observed there were not any posters letting people know there was to be a meeting. People and relatives we spoke with told us they were not asked for their views on the service. This meant systems to encourage people and those that matter to them to make their views known about their care were not in place.

We saw very little evidence of people being given choices about their care or treatment. Staff rarely engaged with people whilst they carried out care tasks and did not ask people for their preferences. Two staff we spoke with told us they did not know how they should support people to make choices in relation to their care. Two care plans we looked at contained information of the person's life history and what they liked to do. However the rest of the care plans we saw held minimal information about the person's life and achievements and their preferences for care.

This meant there had been a breach of the relevant legal Regulation (Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

People we spoke with told us there was sometimes a sing-a-long in the home and they enjoyed this. However we observed people mainly spent their day asleep or staring at the walls. Apart from some people having their finger nails painted we saw very little stimulation during our two day inspection. There was only one activities organiser employed to provide stimulation for the 79 people living in the home. We spoke with the manager about the lack of activities in the home and they confirmed this was an area of concern. They told us care staff were reminded of the importance of activities but that staff did not recognise this.

One person, who had a dementia related illness, received close supervision from staff for most of the day, in line with their planned care. We observed this person spent much of the day sitting in their bedroom with the staff member. Discussions with the member of staff showed that no attempt had been made to introduce activity which would be meaningful for this person. This meant people's life histories were not being used to form a part of how they spent their day.

People who the manager told us were, 'confined to their bed' were at risk of social isolation. There was no evidence to show they were given any social stimulation or supported to be more involved in activities in the home.

We discussed complaints handling with the manager. We were shown a book which listed the most recent complaints. There had been four complaints listed since August 2013. The book did not contain sufficient detail regarding the content of the complaints and the action taken. The manager told us that they did not have separate complaints files for each individual complaint. It was not clear from the documentation available whether the complaints had been responded to appropriately. This meant that we could not be assured that the service had responded to people's complaints satisfactorily.

There was a poster in the main reception area of the home informing people of an external organisation they could approach if they were not happy with their care. However we could not find a copy of the provider's complaints procedure on either of the units. There were no forms provided for people to make comments or raise concerns. We spoke with people about how they would make a complaint and some people did not know how they would do this. One person said, "I don't know if there's a complaints form or not." Another person said, "There are slip-ups sometimes, but they're usually put right."

This meant there had been a breach of the relevant legal Regulation (Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

Are services well-led?

Our findings

We observed on the first day of our inspection that there were enough staff on duty to meet the needs of people using the service. However these staff lacked direction and were not responding to the needs of people.

On the second day of our inspection there were less staff evident in the home and staff told us this was due to sickness. We asked two staff on one unit why so many people were waiting to be assisted out of bed and they told us they had almost 40 people to assist out of bed and they were working their way around the unit and doing their best to get to people. One person who was still in bed at 12 noon told us, "I have been waiting for hours for staff to come and help me get up." We observed that some people did not get the care and support they needed due to there not being enough staff on duty to meet the needs of people.

The manager told us they did not have any systems in place to assess how many staff were needed based on the dependency of the people living in the home. This meant staffing levels were not adjusted based on the current needs of people living in the home and this resulted in people having to wait for care and support.

The people we were able to speak with us told us the staff were very busy and that was why they often had to wait for their bell to be answered. We observed call bells ringing during the second day of our inspection and had to fetch staff on three occasions as there were no staff visible to respond to the call bells.

This meant there had been a breach of the relevant legal regulation (Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

We saw evidence that the provider had systems in place to assess the quality of the service provided to people living in the home. However we found these were not effective in improving the quality of the service. We looked at the records of the 'regulation visits' made by the provider to the home to assess the environment, the care delivery and the records kept. We saw there was a visit completed in December 2013 and the 'regulation manager' had recorded concerns about how people's privacy and dignity, staff being task orientated and not communicating with people living in the home, the smell of urine, the cleanliness of the home and the lack of leadership and direction given to staff. There had been an action plan given to the manager with a deadline of the end of January 2014 for the improvements to be made. There was no evidence of a further visit being made by the regulation manager to see if the improvements had been made, despite the seriousness of the concerns. Visits had been made by the divisional director on behalf of the provider but these visits had not resulted in improvements being made. This left the issues unaddressed and a culture of poor care developing in the home, with no action taken to address this until we inspected the service.

We found there was a lack of storage for equipment and this had not been identified or addressed as part of the provider's audits of the environment. We saw the two main bathrooms/toilets were difficult to access due to hoists and other equipment stored in there. We also found a bed in the main lounge and when we asked why it was there the manager told us there was nowhere else to store it. This did not promote a comfortable environment for people to live and this had not been recognised by the provider or the manager.

We saw meetings had been held with staff and saw that they had been instructed that cigarette breaks outside the home should not be taken in groups but should be taken alone or in pairs, with the nurse's permission. However we regularly observed groups of staff leave the home for up to 20 minutes for cigarette breaks and this went un-noticed or unchallenged by the nurses or the manager. This meant that instructions given to staff were not adhered to and there was no action taken to address this.

There was a general lack of direction and leadership in the home during our inspection. On the first day of the inspection we observed that the nurses on both units of the home spent their time either administering medication or in the nurses office completing paperwork. There was a general feel of chaos in the home with staff not being given any direction from the nurses or the manager to ensure people's needs were met in a timely way. We saw occasions when staff stood in corridors in small groups whispering and talking. This lack of direction resulted in us having to intervene on many occasions and instruct staff to deliver care and support to people.

Where people were regularly having accidents or falls there was no investigation into this to see if there could be

Are services well-led?

learning and steps taken to minimise the risk of further falls or accidents. This was also the case when people were found to have bruising or injuries from an 'unknown cause.' This meant the service was not learning from incidents or accidents.

We observed that the manager rarely left the office, unless asked to do so by us, and that on the odd occasion that they did walk through the home, that they had minimal interaction with the nurses or with staff. Each time we pointed out concerns to them, they asked staff to deal with the issue and then returned to the office. This meant that although the manager knew about the concerns we were finding, they failed to take steps to improve the situation by providing leadership and direction to staff.

This meant there had been a breach of the relevant legal Regulation (Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010) and the action we have asked the provider to take can be found at the back of this report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse** The registered person did not have suitable arrangements in place to protect service users from all forms of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Cleanliness and infection control** The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment** The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 19 1(a) and 2(a)(b)(c)(d)Health and Social Care Act 2008 (Regulated Activities) Complaints**

This section is primarily information for the provider

Compliance actions

	The registered person did not have suitable arrangements in place to bring the complaints system to the attention of service users or to ensure complaints were investigated and responded to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Records** The registered person did not have effective systems in place to ensure records were kept securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 21 (a)(i)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Requirements relating to workers** The registered person was not operating effective recruitment procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing** The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced persons employed.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 (1)(a)(b)(i)(ii)(iii)(iv) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **Care and welfare of people who use services** The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 (1)(a)(b)(i)(ii)(iii)(iv) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **Care and welfare of people who use services** The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 (1)(a)(b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** The registered person did not have effective systems in place to monitor the quality of the service delivery.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 10 (1)(a)(b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.**

This section is primarily information for the provider

Enforcement actions

The registered person did not have effective systems in place to monitor the quality of the service delivery.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 14 (1)(a)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs.** The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 14 (1)(a)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs.** The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Respecting and involving people who use services** The registered person did not have suitable systems in place to ensure the privacy and dignity of service users and to ensure people were involved in decisions about how they were cared for.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Respecting and involving people who use services**

This section is primarily information for the provider

Enforcement actions

The registered person did not have suitable systems in place to ensure the privacy and dignity of service users and to ensure people were involved in decisions about how they were cared for.