Minster Care Management Limited

Attlee Court

Inspection report

Attlee Street
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Date of inspection visit:
18 January 2018
23 January 2018

Date of publication:
16 April 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection was carried out on 18 and 23 January 2018 and was unannounced on both days. We had previously inspected the home in August 2016 and rated it as good.

Attlee Court is a 'care home' for up to 68 people. The home was divided into three units; dementia care, nursing care and residential care. Before the second day of the inspection, the provider combined the units for residential and nursing care. At the time of the inspection there were 43 people in the home. People in care homes receive accommodation and nursing or personal care as a single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified five breaches in the regulations relating to person centred care, dignity and respect, safe care and treatment, staffing and good governance. We asked the provider not to admit any further people to Attlee Court and to increase the staffing levels with immediate effect. The provider agreed to do this and we saw this had been initiated by day two of the inspection.

We found staffing levels were insufficient to meet people's needs and this impacted throughout people's care and support. We saw many instances where people had to wait considerable lengths of time to have their basic needs met.

Staff had a kind and caring attitude towards people they cared for, although they lacked time to spend with people other than when completing personal care. People's dignity was at times compromised when staff were unable to support them in a timely manner. There was a lack of person centred care because staffing levels prevented staff from responding properly to meet people's needs. There was little meaningful activity taking place and people remained in their beds or in their chairs for long periods of time.

Staff knew the signs of potential abuse although they did not all feel confident to raise safeguarding concerns, particularly where this was in relation to whistleblowing.
Risks to individuals were not always assessed, recognised or managed safely. Accidents and incidents were recorded but there was poor management oversight and analysis of these. Systems and processes for managing medicines were not robust.

There was poor leadership and management in the home and quality assurance processes were not rigorous enough to monitor practice or identify risks and areas to improve. Systems for communication within the staff team were not always effective or reliable. Staff did not always feel supported to carry out their role and we found information was not always shared in a timely or supportive way.

People enjoyed the quality of the meals and the cook was knowledgeable about people's individual needs. However, some people's access to drinks was limited and people were not always served drinks when they needed them, such as when they woke in the morning.

People's mental capacity was appropriately assessed although people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. People were not consistently involved in planning their care. Care plans where completed were up to date, although we found two people's care records which were blank, which meant staff had no information about how to support these people. Records of people's daily checks and care provided were not completed in a timely way to show when such care was carried out.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Staffing levels were not sufficient to ensure people's care was carried out safely.

Risks were not all assessed or mitigated and systems for managing medicines were not robust.

Accidents and incidents were not analysed to ensure learning from these.

Is the service effective?

Inadequate

The service was not effective.

Staff did not all feel supported and able to develop in their role. Staff supervision was not used to support and encourage staff or identify training needs.

People's mental capacity was appropriately assessed although staff did not always support people in the least restrictive way possible.

People enjoyed the food but staffing levels impacted upon staff's ability to provide enough for people to drink, particularly first thing upon waking.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff worked hard to try to meet people's needs, although poor staffing levels impacted upon staff's ability to provide appropriate care.

Staff understood how to ensure people's privacy and dignity, but people's continence needs were not always met in a timely manner.

People were not always actively involved in making decisions

about their care and support.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not personalised to people's individual needs.

Activities and opportunities for people to engage in meaningful occupation were limited.

People and relatives knew how to complain, but not everyone was confident their complaints would be acted upon.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of leadership and direction for staff.

There was poor oversight of the risks to people's health, care or well-being.

Systems in place to assess or monitor the quality of the service were not robust.

Attlee Court

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 checked 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.

We inspected the service on 18 and 23 January 2018. The inspection was unannounced on both days. The inspection team on 18 January 2018 comprised of three adult social care inspectors, a specialist professional adviser in nursing care and an expert by experience, whose experience was in caring for a person living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 23 January 2018 there were three adult social care inspectors.

We reviewed all information about the service including information sent to us by the provider as well as liaison with stakeholders including the local authority. This inspection was scheduled partly in response to concerns raised with us about staffing levels and poor quality of care.

We spoke with 24 people who used the service, seven relatives, eight staff, the registered manager, the area manager and the nominated individual. We looked at seven records of people's care and records to illustrate how the service was run. We looked at premises and equipment and documentation relating to the safety of these.

Inadequate

Is the service safe?

Our findings

Staffing levels were not adequate to meet people's needs. We arranged the inspection in order to see part of the night shift as we had received concerns about staffing levels at night. The home had three separate units; dementia care, nursing care and residential care. We made observations of staffing levels during both days of our inspection and found there were not enough staff. When we arrived at 7am on the first day of inspection there was only one member of staff on duty overnight on the dementia unit. They told us another member of staff had been unable to come to work, but that they were able to ask for help from colleagues on another unit if needed, however we saw doing this reduced staffing levels on that unit. A member of staff told us, "Staff from here [dementia unit] have to go across to help on the nursing unit at night. They run it as if it is one unit."

On the nursing unit we found there were two night staff, one of whom was a qualified nurse. There were 11 people with high dependency needs, 10 of whom were nursed in bed. On the residential unit we found there were two members of night staff for 21 people and staff told us more than half the people needed two staff at a time to support them. This meant whilst staff were busy attending to one person, there were no staff available to support anyone else.

During the day on the dementia care unit there were two members of staff caring for 11 people, three of whom required both staff to attend if they needed assistance. We observed the staff attending to people when required, however to do so they often had to break off from assisting another person or, for example, when administering medicines or serving meals.

On a number of occasions on the dementia care unit we saw people were left unattended in the lounge for extended periods as staff attended to people who had chosen to remain in their rooms. This meant staff were unable to monitor people, for example people who may be at risk of falls or from behaviours which challenged themselves and the service. Staff we spoke with told us they were not always deployed in sufficient numbers to meet people's needs in a timely way. One member of staff said, "We possibly don't have enough staff." Another staff member told us, "It's chaos on this unit. You just don't have time. Basic cares get missed because we're rushing. Staffing has been like this for a long time." Staff gave other examples such as people remaining in chairs for extended periods of time and people remaining in bed because staff did not have time to encourage them to get up. Our observations during the inspection showed people remained seated for long periods, including from getting up to and including having their lunch in the same seat.

We saw staff were extremely busy but unable to cope with people's needs and this compromised people's safety and well being. Staff told us they felt stretched and we saw they rushed from person to person trying to offer support. We saw on the residential unit three people were calling for staff, one person who was sitting on their bed said they had been waiting around three hours. We saw this person was in a state of undress and they told us they felt cold but were unable to summon staff to help them with their clothing. We saw staff were supporting others and so we assisted the person to put their shirt on. Another person told us they had been waiting over half an hour for staff to assist them to use the toilet and said their bed was wet.

Another person said, "We are glad you've come to check. This is how it is, always the same. It's not the staff's fault but they need more of them".
On the nursing unit on the first day of the inspection we saw people were not offered breakfast until after 10am and some people told us they had not been offered anything to drink. On the first day of the inspection we asked the provider to ensure more staff were available to meet people's needs throughout the home.

Staff said they were concerned people's care was not safely met because they were unable to see or know if, for example, a person had fallen. They said the layout of the unit did not enable them to hear or see what was going on if they were in another part of the unit. We heard people's buzzers sounded constantly with little cessation.

People and their relatives overwhelmingly told us there were not enough staff. One person said, "Staff say, 'we are too busy, we will come back'. it might be an hour before they come back." Another person said, "People in wheelchairs are told, 'you will have to wait', it must be awful for those who have to wait because they have to have someone go with them." and another person said "I press the buzzer, then I press again sometimes can wait half an hour."

Relatives told us, "I like to help as they are short of staff", "They can't come straight away, they come when they have finished. There aren't enough staff, you have to wait longer" and "Two staff is not enough, but the lasses are lovely."

On the second day of the inspection we saw the provider had increased staffing numbers. There were two members of staff on duty overnight on the dementia care unit and three staff were assigned to the unit during the day. We saw staff were able to maintain a more consistent presence in communal areas, and had more time to interact with people. We saw on the second day of the inspection, there was more staff attention for people when they woke and people had improved access to drinks. However, we saw some people still had to wait for staff to support them. On one occasion an inspector was looking for 25 minutes for a member of staff available to support a person.

We found the registered manager had taken the decision to move the people from the upstairs nursing unit to the downstairs unit following the first day of the inspection. They told us this was for staff to be more visible and accessible to each other, and there had been an increase in the number of day staff available. Night staff on the second day of the inspection told us they were just as stretched, only with more people on the unit to care for. Although staff were more visible to one another this did not change people's dependency needs. The registered manager told us a dependency tool was used to calculate the number of care staff needed and this was based upon people's individual risk scores. However, we found what we observed of people's dependency needs and what was recorded were not always the same.

We checked a sample of staff files and saw recruitment procedures had been followed to ensure staff were suitably vetted before working in the home. One new member of staff said they had shadowed more experienced staff before working unsupervised. We looked at the staff rotas and found some staff had worked many shifts in a row, meaning their working week was sometimes 72 hours long and in one case a member of staff had worked 96 hours without a day off. We asked the provider to review this so staff were able to work safely without being overtired. Staff we spoke with told us they often had no time to take a break, particularly on the night shift. One member of staff said if they stopped it was 'only to eat' and they told us, "A break for us is when no one is buzzing".

We concluded there was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014, Staffing.

We saw there were assessments in people's care plans to show how risks associated with people's care and support had been identified and assessed. These included risks such as falls, mobility, skin integrity, nutritional health and ability to use the emergency call bell system. We saw these assessments were updated monthly. However, some information in risk assessments was not always clear. For example, falls risk assessments were adjusted depending on the number of falls someone had had over a period of a year. It was not always clear when the falls had occurred, which meant the assessment may not have been an accurate reflection of current risk.

There were plans in place which showed how staff could minimise the impact of people's behaviours which challenged themselves or others. This included guidance to show how the person may be distracted effectively. We saw records were kept detailing any incidences of behaviours that challenge, together with detail as to the circumstances in which the incident had occurred and what had been effective in de-escalating the incident.

Staff knew what to do in the event of a fire and confirmed they had received fire training and taken part in fire drills. We saw personal emergency evacuation plans (PEEPs) in people's care files detailed the support and equipment people required if they had to be evacuated from the home. However, a PEEPs folder kept by the registered manager for the whole home did not include all the people living in the home. The registered manager told us they would address this immediately. However when we returned on the second day, people had been moved to different rooms, staff were not familiar with where each person was located and the PEEPs had not been updated accordingly. This meant in the event of an emergency it may be difficult to locate people to ensure their safety. The inspector asked the registered manager to ensure this was done as a priority, which they agreed to do .

Records of accidents, incidents and safeguarding did not always show what actions had been taken to ensure future risks had been minimised. There was little evidence of analysis of accidents and incidents to enable the service to learn lessons that would improve safety and quality in the service. Where accidents and incidents involved equipment, staff practice or conduct, there was no investigation evident, to identify continued safety issues or minimise the risk to people from repeated events. For example, where one person had slipped between the bed and the wall, the accident record stated there were no brakes on the bed, yet there was no evidence this had been addressed. We saw some beds in the home which did not have brakes on and would easily move in this way. The registered manager's overview of safeguarding concerns showed a different number of safeguarding concerns to the individual ones we saw recorded. This meant procedures and processes to ensure safeguarding had the right level of scrutiny and oversight were not robust.

Staff we spoke with gave examples which demonstrated they understood how to identify the signs of potential abuse and their responsibility to report it. Some staff told us they did not feel confident raising concerns to external bodies such as the local authority safeguarding teams or the CQC. We saw a memo on a noticeboard informing staff they should speak to the registered manager before raising safeguarding concerns. We discussed this with the registered manager, area manager and provider during feedback. The registered manager told us they were concerned that reports which should have also come to their notice had not always done so. They told us they would clarify this instruction to staff.

The systems for managing medicines were not robust. We found medicines were stored securely and most medicines were appropriately signed for in the medicines administration records (MARs). However, one person's MAR showed eye drops had not been signed as given for three days and staff were unable to

explain why. Another person's medicine had been written on a MAR chart without any staff signatures, which meant there was no accountability or accuracy check.

Staff told us they had recently changed the pharmacy, but as a result we saw there was missing documentation, such as PRN (as required) protocols, controlled drug patch and topical medicine records. This had the potential of increasing the risk of error involving omission, rationale for PRN medicine and over medication in relation to patch applications.

For example, one person had a PRN medicine, yet the protocol was unclear as there was a difference between what was on the prescription and the protocol. Where medicine had been given to calm people's anxiety, it was not always clear from the records if any other actions had been taken by staff to minimise distress.

We checked medication patches and one MAR chart showed on four occasions drug patches were missing when staff went to apply a new patch. There was no documented evidence to show what had been done about the patches that were missing, and it was not possible to verify how long the person had been without the medication. Records to show controlled drug administration and stock balances were not clearly maintained.

We saw checks were made of the clinical room and the medication fridge, but no checks had been completed on the dementia care unit since 9 January 2018.The provider sent us a copy of this record following the inspection to show the checks had been carried out.

There was no homely remedy policy so if a person complained of pain and was not prescribed PRN pain relief, no medicine could be given until a prescription was obtained. We found evidence one person had not been given PRN medication, despite complaining of pain. One person we spoke with and their relative told us how no pain relief had been offered when they had a fall, despite complaining of pain.

We concluded there was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

We made observations around the home and saw it was well maintained and clean. Relatives told us, "The place is clean, no problems. The laundry is fabulous." and "It's lovely and warm, clean and very welcoming."

Staff had access to personal protective equipment (PPE) and used this when needed. We identified furnishings in one room were badly soiled and may have been an infection control concern. We asked for this furniture to be replaced, and this was done during our visit.

Inadequate

Is the service effective?

Our findings

Staff told us supervision and support was not consistent and did not meet their needs. Staff told us they did not feel they had a regular chance to discuss their individual performance, training needs and practice during supervision meetings. Staff described the supervision process as passing information to them, for example to discuss examples of poor practice or to update staff on new processes. Records we saw confirmed this. One member of staff said, "Supervisions aren't done. They only happen when something's wrong." Staff were not able to tell us about any recent appraisal meetings. We asked the registered manager for supervision records for two staff, but they were unable to provide this.

Staff said they had access to online training which they were expected to complete, and could tell us about other training, such as for moving and handling, which took place in a classroom environment. Staff said online training was not always effective and they 'did not feel they were actually learning'. We looked at the training matrix which showed staff had completed a range of training, although there was no reference to training in dementia care. On the second day of the inspection we two staff arrived to do first aid training. However, this had been cancelled and no one had informed staff. One member of staff told us this was the second time it had been cancelled and communication from management was very poor.

We saw where new staff were inducted there was a checklist to show the aspects of work they had completed. Staff told us they shadowed more experienced staff when they first started.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found people had the appropriate authorisations in place

Care plans contained assessments of people's capacity to make a range of specific decisions. We saw records to support a conclusion that the person lacked capacity in each area, and saw best interest decisions were made which involved those who knew the person well.

We looked at conditions that had been placed on the authorisation of one person's DoLS. There was no evidence in the care plan that this condition was being met. The person was supposed to be supported to do a particular activity and we could not see they had been offered this as a choice. We discussed this with the member of staff that wrote the care plan, and they updated the activities section with guidance for staff about adhering to this condition.

Staff we spoke with said they had received training in the MCA and DoLS, and could describe what was meant by capacity and the responsibilities they had when a DoLS was in place. One member of staff said, "The MCA assessments tell us whether someone can make a decision about something or not. There is information about it in the care plans. We talk to families and GPs to help us understand someone's capacity." Another member of staff expressed concern about the training they had received. "I don't think we have had enough training on DoLS. I have asked [name of registered manager] but I've given up now."

Although we saw staff recognised when some people had restrictions in place which needed consent or a DoLS, this was not always being effectively managed. For example, we saw one person had a sensor mat in their room, although we observed them mobilising independently. Their care plan showed they were considered a high falls risk due to having had falls in the previous year. We saw the person had not fallen for some months and asked staff whether the person needed the sensor mat, which would alert staff that they were mobilising and therefore reduce their privacy. A staff member told us the person was very independent and was occasionally frustrated that staff came to check on them when they were choosing to walk around or leave their room. They told us they would review the risk and need for the sensor mat.

We saw some evidence of effective response to changes in risk levels as a result of reviewing risk assessments and monitoring tools such as those for people's weight and skin integrity. For example, in one nutritional assessment we saw the person's risk had increased, and the action listed on the assessment, to refer the person to a dietician, had been completed. However, we found advice given by visiting professionals was not always followed. For example, the dietician had advised one person should be weighed weekly. The person's care plan had not been updated to reflect this and the records showed the person was being weighed monthly not weekly.

There was evidence people were supported to access health and social care professionals when needed. For example, GPs, district nurses, chiropodists, opticians, advocates and hospital services.

Information about checks which staff made on people, such as to reposition them or check on their safety, was not recorded at the time the staff carried out the activity. This meant there was a risk that detail or actions taken may be forgotten. Staff we spoke with told us they were not always able to complete or record checks in a timely way. One staff member said, "There are not enough of us, we always have someone else to go to and their needs come first. We fill in forms as soon as we have chance, but that is sometimes a while." We saw night staff sat with a pile of records at the end of their shift, updating information from 2am. Staff told us they had carried out the necessary care, but had not had time to record this due to needing to move on to the next person.

On the residential unit we saw as people woke up staff were unable to provide drinks for them. On the first day of the inspection, there were six people dressed and in the residential lounge at 7am, with no evidence of any drinks. One person said they had 'been up for a good few hours' but had not been offered a drink. Another person said they had to wait until breakfast time for anything to drink but said they would 'love a cup of tea'. Another person told us their mouth felt dry but said staff were busy, "It's a busy place, I will have to wait my turn". Staff told us they had not been able to make any drinks because they were supporting people to get up. Staff said they were aware they were not meeting people's needs and felt frustrated they could not do more.

We concluded there was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

In comparison, on the dementia unit we saw people were offered drinks when they got up, and were able to

make choices about the sort of breakfast they wished to have. When people needed support to make choices we saw this was given. For example, one person found it hard to pick a flavour of juice from a list, and we saw a member of staff take cartons to them to help them identify their choice.

Staff told us the dementia unit did not have a supply of drinking water, and staff had to get water to drink from the kitchen on the lower floor. We asked about the water in people's en suite bathrooms. The staff member we spoke with said they did not know whether the water was drinkable, but would dissuade people from drinking it as a precaution. We saw one person went to their room with a glass, and staff confirmed they would be able to help themselves to water in their rooms if they chose to. This meant people may drink water that was not intended for consumption. There was a drinks dispenser in the lounge on the ground floor which staff used as well as the supply of water from the kitchen. We saw staff made drinks for people on request, however noted a lack of drinks that people could get for themselves, either in communal areas or in their own rooms. Staff who worked at night said they were able to get snacks and drinks for people if they wanted them.

We looked at food and fluid intake records for people at nutritional risk. These were completed but they were not always added up or reviewed each day to make sure people had received sufficient to eat and drink and there was no target to guide staff as to how much people should be aiming to drink.

We observed breakfast and lunch service on the first day of the inspection, and breakfast on the second day. Where people needed assistance, for example to cut up their food, we saw this was either requested by the person or offered to them before the member of staff intervened. When people were not eating staff gave encouragement and offered alternatives.

We spoke with the chef who demonstrated a good knowledge of people's dietary requirements and adjustments that needed to be made to meet people's particular needs. These included adaptations for diabetes or for people at risk of choking. Food was regularly fortified with cream, butter and milk powder to assist with managing people's weights, and additional fortification such as high calorie drinks for people at high risk of losing weight.

Meals were made for people which were allergen free or culturally suitable when these were needed. There was a four weekly menu, and people had been consulted about the types of meals they wanted. During the meal services we saw people were offered choice from a menu when seated in the dining room. Some people asked for an alternative, for example, a salad and we saw this was made for them. The provider told us a wide range of snacks were available to people, such as cakes, pastries, chocolates, biscuits and fruit. However, we observed only a limited range of snacks offered to people in between meals.

People said they enjoyed the food. One person said, "The food is spot on." And another said "The food is good, I don't eat much." Relatives said, "The food is good" and "The baking is lovely the food is good when there is entertainment on."

The design of the dementia unit was not always reflective of good practice in creating an effective environment. Good practice was seen in single colour flooring, high contrast colour scheme to highlight handrail and some signage to identify rooms such as the dining room, lounge and bathrooms. However, there was a lack of directional signage to assist people to find these areas of the unit independently. We also noted a lack of items which would enable people to engage in independent activity, such as books or paper, and tactile surfaces or objects.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us they thought the staff were caring on the whole. One person said, "Staff are lovely" and another person said, "The night staff are lovely, very very kind" and another person said, "Some staff are good some are not". Relatives said, "They have got some lovely carers there are fewer agency carers", "The care staff are fantastic." and "Nothing is too much trouble for the staff."

We saw staff worked very hard to try to meet people's needs and they were patient and caring overall. Staff were mindful of people's privacy and dignity and took measures to ensure personal care was discreet. However, poor staffing levels impacted directly upon people's care, particularly with regard to people's continence needs and this compromised people's dignity. One person told us, "At my age it's not right if I wet myself, it's degrading." Another person said, "Holding on [for the toilet] is so painful, it really hurts."

We concluded there was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

We observed staff were caring and friendly in their approach to people who used the service. We saw discretion used when discussing personal care needs with people. Staff spoke to people at eye level and rephrased questions and answers for people who did not understand what was being said to them. On the dementia care unit we saw one person became distressed because they wanted to see a relative. A member of staff reassured them and told them what time their relative was coming and how long that would be. When this did not reduce the person's distress the member of staff asked if they would like to speak to their relative, and brought them the phone. They encouraged the person to remember the phone number and assisted them to dial. They then gave the person some privacy as they spent time speaking with their relative.

In contrast, on the nursing unit we observed staff not responding when asked for assistance by a relative of a person using the service. The relative asked a staff member where everyone was. The staff member replied, "Good question" and carried on with what they were doing. The relative came out of the person's room for a second time and asked for assistance. Another member of staff replied, "Just a minute, I'm busy now." This staff member was looking for information in a file and did not go to see the person until we intervened.

Staff we spoke with could describe how they promoted and respected people's privacy and dignity. Examples included making sure people were covered and doors and curtains were closed before supporting them with personal care, and respecting the fact that Attlee Court was people's home.

Care plans contained useful information to assist staff in forming caring relationships with people, such as people's hobbies, interests, working lives, important relationships and cherished memories such as pet names and holidays. We observed interactions which showed people and staff knew each other well. People were addressed in their preferred ways, and referred to staff by name.

Inadequate

Is the service responsive?

Our findings

Staffing levels had a direct impact upon people's needs being met and we found care was not person centred, timely or responsive. We saw several examples of where people had to wait for the toilet. One person told us they had asked staff before breakfast at 8.30am if they could have support for the toilet and they had been told staff were busy with other people, but would support as soon as they were able. The person had been waiting for well over an hour and they were becoming distressed. At 9.45 am we intervened and asked the unit manager, who said they were waiting for staff to be available. We then went to ask the registered manager who supported the person themselves with the assistance of the administration staff. On the second day of the inspection, we saw one person waited 25 minutes to use the toilet because they were unable to summon staff. The person told us, "They know I need to go, they just keep saying 'in a minute', and walking past. I'm really desperate". We intervened to locate staff to attend to the person.

People in the residential unit waited for staff to support them to be up and dressed. We spoke with one person on both days of the inspection. They told us, "I see to myself, it's a slow process but I can't rely on the staff. It's not their fault, they can't be in more than one place at a time". Another person said, "Well, I've been awake for a couple of hours but I just have to wait. I can't do anything without their help. I do need the toilet but I know there's not just me here to look after."

We observed handovers on both days of our inspection. Staff arriving on the dementia unit for the day shift received an update on each person, with observations as to their dietary intake, sleep pattern and general health. We observed a number of discussions about people whose needs had changed, and saw appropriate referrals had been made.

On the second day of the inspection we observed the residential and nursing unit in their walking handover. This involved night staff walking through the unit with the day staff and giving a brief update about each person. This did not always involve seeing each person directly and we saw updates were sometimes given standing outside the person's closed door. Staff we spoke with said they were not sure what the value of walking round the unit was, particularly when it involved the whole staff team. This meant there were no staff left to respond to people's needs during the handover. One person who was waiting in the lounge for staff support commented upon this. They said, "Just look at them, marching down the corridor, but they won't come in here and I need someone to help me". We observed this person called out as nine staff completing the handover walked past the lounge in view of the person. The person called out repeatedly for the toilet for 20 minutes until we located a member of staff and asked them to support the person.

Although we saw the provider had increased the staffing levels by day two of the inspection, it was not clear to us how this was responsive to the dependency needs of the people at Attlee Court or how thoroughly this had been assessed. The provider's decision to move people with nursing care needs had been implemented quickly and staff told us they did not know people's needs or where they were located in the building.

We heard one person in their room, behind a closed door and they sounded distressed so we knocked and went in. The person was unable to verbally communicate but we could see they were upset, by their frantic

gestures and facial expressions. The person did not have access to a call bell. We saw in the person's room some picture cards to support their communication, and through pointing to these the person told us they were angry, frustrated and thirsty; they were still in bed and wanted to be up in their chair. The person gestured they felt hungry and had not been supported to eat or drink and it was 9.45am. Staff told us they had not yet had time to attend to the person. We saw the person's records showed they had been supported with nutrition at 10.30pm the night before but there were no further entries. We spoke with the nurse in charge who said they did not really know the person as they had not been in post long, but thought they should have had some support and agreed to attend to the person. We discussed this person's care with the registered manager and operations manager and asked for a review of their care.

Some care records we looked at showed there had been an assessment of people's needs before they began using the service. This assessment was used to produce a series of care plans, including those for nutrition, mobility, personal care, activities, medication, oral care, mental state and pressure care. In addition we saw care plans were written for specific conditions, such as those for medical conditions such as angina and cancer. However, we found there were two people in the home whose care plans were not written and the information was blank in relation to risks and their care and support needs. The registered manager told us the two people were new to the home. Records showed they had been at the home 10 and eight days respectively. One person had some safe swallowing advice in their file yet there had been no assessment of the risk of choking. They had recently fallen before coming to the home yet there was no information about the risk of falls. Neither of these people had any emergency evacuation information. This meant the provider had not assessed the care and support needs, risks or dependency of these people.

We spoke with three people who said they had never seen any care plan or records relating to their needs and had not been consulted about their care requirements or preferences. Two of these people were those for whom their records were blank. On day two of the inspection, we saw a member of staff completing these but without consulting the people themselves. We spoke with the member of staff who was completing the documentation and asked why they did not do this with each person. They told us it was more efficient to complete the care plan and then discuss this the person afterwards.

Completed care plans contained evidence of regular review. Each section was commented on monthly, with updates to information added. Some information in the review sections contradicted the information in the care plan. For example, in one care plan we saw conflicting information about the number of staff needed to minimise risks associated with their mobility. This meant staff may not always have seen up to date information and could put people at risk by providing unsuitable support. We found some information in risk assessment reviews may not always have been current. For example, falls risk assessments included a score derived from accidents in the last year, however there was not always information to show when the falls had taken place.

We found there was a lack of evidence of people's involvement with the processes of care review. We saw each file contained information about whether the person wanted to be involved in writing and reviewing their care plans, and whether they wished a family member or advocate to also be involved. Although several care plans showed people wanted to be involved, there was no evidence such as records of conversations with them or signatures to confirm who had been involved. We did see information in records of contact with families that some relatives had been asked about their satisfaction with the care provided, but this did not constitute a formal review. We saw some relatives who were not named on the consent form had been contacted in this way. This may not always be appropriate as the person using the service may not have wanted them to be consulted.

On both days of the inspection we observed a lack of activities for people to engage in. Some people on the

dementia care unit watched the television, and one person asked for some music to be put on. Staff asked other people in the room if they would like to listen to music before putting it on. Activities records in people's care plan did not evidence people had access to regular meaningful activities. Most monthly records relied on generic information such as, 'Watched television,' and 'Socialised with other residents.' We saw in the records for one month that a number of people had attended a concert by an external entertainer. Although care plans contained some information about hobbies and interests, we found a lack of evidence that people were supported to engage in these activities. We saw the activities coordinator tried to engage some people in activities, such as nail painting and bingo, but this was not sufficient to provide meaningful activity to people living at Attlee Court.

People's care plans included documentation relating to the kind of care they wished to receive at the end of their lives, although we found this was limited in scope and did not always evidence discussions had taken place with people and their families. For example, most end of life care plans included guidance to, 'respect people's wishes,' although there was not always information to show what these wishes were, such as who the person may wish to have present, or whether they had spiritual or cultural needs which they would want to be met.

We did not see any evidence of consideration of the accessible information standards in the writing of the care plans. For example, there was no assessment of people's cognitive and sensory abilities in relation to accessing their care plan. For example, an assessment of whether the person could be supported to access their care information in large print, easy read formats or alternative languages.

We concluded there was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care.

We looked at records of complaints received by the service, and saw there was a process in place which involved the registered manager carrying out appropriate investigations and sending a response to the person who had contacted them. There was some brief analysis of complaints received over time, which identified any consistent themes and showed what action had been taken as a result.

Inadequate

Is the service well-led?

Our findings

We found the home was not well led. There was a registered manager in post who had been registered since December 2016. We asked the registered manager how they developed an overview of risks associated with care of people and the environment of the home, however they could not tell us. We asked them to take us on a walk round of part of the home to show us how they monitored the service and ensured action was taken when needed. We found the registered manager was unable to identify risks in the environment or notice issues picked up by the inspection team. The registered manager said they carried out a daily check of the home and completed a form to show the areas checked and any actions identified. We looked at the checklist and saw this was completed more ad hoc than daily and did not cover key areas, such as staffing levels.

We found the registered manager did not have robust processes in place to delegate actions and check on progress to their completion. For example, the registered manager told us they asked staff to take action in meetings, however did not have a record of this or an overall action plan that demonstrated how meaningful improvements were made. Records of some audits were in place but these did not always demonstrate how robustly checks had been carried out and there was a lack of management oversight. For example, we identified a mattress that was damaged and malodorous and asked to look at the mattress audit. This had been completed by a member of the domiciliary staff. The mattress we identified had been checked on the 16 January 2018 and certified as fit for use, when this could not have been the case. We did not see any evidence the registered manager had checked this audit. There were no up to date records of any safety checks for bed rails available during the inspection and the registered manager was unable to give us any assurance of people's safety to ensure people were not at risk from using this equipment. The registered manager told us the maintenance staff checked the equipment, although they were unable to confirm they had received any such training, or how they knew what to look for. They confirmed they maintained no oversight of these checks and we identified risks to three individuals from this equipment. The provider sent us a check sheet following the inspection to show bedrails were checked weekly, but this record did not provide evidence of robust checks .

We saw the registered manager lacked consistency when engaging with people and staff. On one occasion we saw the registered manager entered a dining room without speaking to the six people who were having breakfast, stayed in the room for several minutes and left without speaking. On two other occasions we saw the registered manager walked past people in the corridor without acknowledging them.

Some relatives we spoke with said they knew who the registered manager was, but not all said they had met them. Some relatives said they felt they could approach the registered manager with any matters, although one relative we spoke with said they had tried to speak with the registered manager but found them unapproachable.

Staff were unable to offer examples of good leadership in the service. Several staff we spoke with said they found the registered manager unapproachable, or told us they and the registered manager did not speak to each other. Staff told us they sometimes saw the registered manager in the units, but said the registered

manager rarely engaged with them or people who used the service. One member of staff said, "[Name of registered manager] walks around but doesn't speak to people. [They don't] care. [They're] not approachable, [they don't] want to know." Some staff expressed a view that Attlee Court was not a good place to work. Comments included, "There is a lot of friction between people here", "It has been a good place to work, but not now. Staff get on well, but that's it," and "Morale is awful, something has to change."

We found there had been a lack of communication about changes in the home. On the second day of our inspection we found people had been moved from the first floor nursing unit to the ground floor. We asked staff how this had been explained to them. Most told us they had received no explanation. One staff member said, "There has been no explanation from [name of registered manager]. What I know is through hearsay. I've heard staffing levels have changed, but it's just what I've heard." During the day of our inspection we observed one staff member came to the dementia unit and expressed surprise that the neighbouring nursing unit was empty as they had not been told on arrival. Some people we spoke with said they had been consulted about the move and one person said they had chosen the room they wanted to move to. However, two people told us they had been informed it was happening, but there was no choice in this for them. One person said, "They told me I was moving, but it doesn't mean I'm happy about it."

We asked to see plans and risk assessments carried out prior to moving people. The registered manager said they had spoken with people and their relatives and obtained consent. We saw some risks had been identified, for example distress to residents, moving of equipment and possessions, and the impact of change of environment, staff providing care to people they did not know well and change of routine. The actions identified included, discussions with people and families and timing the transfers in ways which did not impact on people's health or care needs. Discussion with the nurse on duty and the staff team was also an action identified to minimise risk.

We found the relocation of people in response to concerns raised on the first day of the inspection was not well planned or implemented. We found on the second day of the inspection staff lacked knowledge of where people were and what their needs were. We saw a handwritten list on the meal trolley which showed people's dietary needs but there was no clear system to show who had eaten or been served their meal. We asked staff about this and they said, "It's chaotic at the moment, we have to ask each other, it's because it's all just changed". We heard staff ask one another about individual people's needs before they were able to offer support and at times this meant people had to wait.

We spoke with the area manager who said they had been in post for three months. They told us they visited twice weekly and we saw reports of their visits. They said they carried out reports in the style of a CQC inspection, using the key lines of enquiry to measure the quality of the service. We saw the service had been rated as 'good' by the area manager. However, the report did not consider the robustness of the manager's audits or the staffing levels and impact upon people in the home. We spoke with the provider who told us although did not visit the service frequently they relied on the quality of information coming from the registered manager and area manager.

We concluded there was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.