Mr Atique Rehman

Royd Hill Nursing Home

Inspection report

Sutton Lane
Sutton In Craven
Keighley
West Yorkshire
BD20 7AJ
Tel: 01535 633499
Website: www.example.com

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Ratings

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

Overall summary

We inspected the home on two days. The first visit was carried out on the 4 February 2015 and the second visit was on 7 February 2015. Both visits were unannounced.

The visit on 4 February 2015 was a routine inspection. However, the visit on 7 February 2015 was carried out to check that action had being taken to address the serious short falls that we had identified on 4 February 2015. We had particular concerns relating to the care practices at Royd Hill Nursing Home, which put people at risk of receiving inappropriate care and treatment, of receiving insufficient fluids and food, receiving inappropriate support around pressure ulcer prevention and unsafe moving and handling techniques.

Such was our concern in relation to these practices that we requested an urgent action plan from the provider to minimise the risks to people at the service. This was requested from the provider on 9 February 2015. The action plan returned by the provider on 10 February 2015 lacked detail, was aspirational and did not provide any

Summary of findings

means by which the provider would monitor and improve the care being provided. An updated action plan was again requested from the provider on 10 February2015. This also failed to address the concerns we had highlighted.

We previously inspected Royd Hill Nursing Home in August 2013, and we found people were not fully protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening in relation to management of people's personal money. We also found at the inspection in August 2013 that there were not enough qualified, skilled and experienced staff to meet people's needs.

We visited Royd Hill Nursing Home again in December 2013 to check that the necessary improvements had been made. We found that the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We also reviewed the staffing arrangements and found that the increased staffing levels, which had been agreed on the day of our previous inspection in August 2013, had remained in place. Overall there were enough staff on duty to meet people's needs. However, staff told us that at peak times, usually around the teatime period, they felt under pressure to provide an adequate service especially when the nurse on duty was busy carrying out a medication round and was not available to help with the teatime meal.

Royd Hill is a care home which provides nursing and residential care for older people and for people who have dementia. It is situated in the village of Sutton in Craven; it is near to transport links and local shops. The home is set in private grounds and there is car parking available.

At the time of this inspection, the home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had however employed an acting manager, who had been in post since early October 2014. The acting manager has not yet applied to register with CQC.

The acting manager was present during our first visit on 4 February 2015 and the deputy manager assisted with the inspection on 7 February.

On 4 February 2015, we walked around the premises and checked the records relating to cleaning schedules and audits. We found multiple examples of inadequate cleaning and poor standards of maintenance and décor. For example, chairs, walls, door architrave and carpets were stained and marked. There was a strong unpleasant smell of urine, particularly in the communal lounge area and the ground floor corridor. We noted that pull cords in toilets were dirty, some were covered in what looked like faeces and radiators were rusty and stained. We noted that wheelchairs were stained with food waste and spilt drinks and that easy chairs had torn upholstery and stained cushions. We also found that crockery and cutlery cupboards were stained and had chipped delaminated exposed areas, making adequate cleaning difficult. Some curtains and wall coverings were stained with what looked like food and in some cases bodily fluids. The kitchen area, despite being awarded a five star rating by the environmental agency in 2014, was not clean. Freezers, fridges and the floor were dirty. There was food debris found under the sink area and waste bins were overflowing. We contacted the environment agency to discuss our findings. They were due to revisit the service to support the staff to improve their awareness of the importance of infection control and were awaiting a mutually convenient time to do that.

We noted that a significant number of people looked unkempt and dishevelled in terms of their personal appearance. For example, people were seen to have long fingernails with dirt underneath, people's hair was not groomed, looked greasy and unwashed and men were unshaven. After breakfast and lunch, we noted that some people were supported back to the lounge area and they had food stains on their clothing, hands had food on them and people had dried food around their mouths. Staff did not attend to this detail which compromised peoples overall dignity and respect and was indicative of a service where people were not given basic care, thus placing them at risk of infection and neglecting their welfare and wellbeing.

We found that people were not being provided with adequate fluids to prevent them becoming or being dehydrated and that people's nutritional needs were not

Summary of findings

always being met. During the course of the inspection we found that although people had lost significant amounts of weight, little or no action had been taken to address this. We also saw that people, who needed support with their meals and drinks, were not being assisted to eat or drink regularly or in an appropriate way.

This meant that people were not always receiving adequate nutrition, were losing weight and this put them at risk of being undernourished.

During our observations in communal areas, we saw that some people were not regularly moved despite them being at risk of developing pressure ulcers, according to their care records.

The home did not have an effective quality assurance system in place and there was no auditing schedule. We found this put people at risk of potentially unsafe or inappropriate care. This meant people were not benefiting from a service that was continually looking at how it could provide a better service for people.

Staff training was inadequate and staff had not received training in accordance with their roles and responsibilities.

Medicines were appropriately stored and administered.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some people told us they felt safe living at Royd Hill. However, during our inspection we found that the service was failing to provide consistent and safe care. The inspection team noted that people's needs were not anticipated or dealt with at the time they occurred.

Staff had not received adequate training and poor care practices were seen during the inspection visit, including staff using illegal lifts when moving people.

We also found the home was dirty and in need of a good clean and there were malodours in some areas of the home. There were inadequate cleaning schedules.

Concerns were highlighted by the fire authority on 3 February 2015, about the lack of a suitable and sufficient risk assessment for the premises, that in the event of danger persons would be unable to evacuate the premises as quickly and as safely as possible and that appropriate procedures and safety drills were not established. There was also a concern about inadequate training for staff.

There had been a significant number of safeguarding referrals to the local authority. The provider was working with the local authority to address matters and this involved attendance at meetings and providing regular updates regarding the running of the service. However, the number of ongoing safeguarding matters was of concern. The safeguarding concerns were regarding weight loss, dehydration, lack of proper recording and poor care practices.

Medicines management was good; medication was appropriately stored and administered as required and according to the prescriber's instructions.

Safe recruitment practices were followed to ensure that people were suitable to work at this setting.

Is the service effective?

Inadequate

The service was not effective.

We found that people were not being provided with adequate fluids to prevent them becoming or being dehydrated, that people's nutritional needs were not always being met. This meant that people were not always receiving adequate nutrition, were losing weight and this put them at risk of being undernourished.

We also found that although people had lost significant amounts of weight, little or no action had been taken to address this. We also saw that people, who needed support with their meals and drinks, were not being assisted to eat or drink regularly or in an appropriate way. This meant that people were not protected from the risk of harm or injury.

During our observations in communal areas, we saw that some people were not regularly moved despite them being at risk of developing pressure ulcers, according to their care records.

Summary of findings

There was no adequate training programme for staff; some staff had not received any training since 2013. This meant that staff were not sufficiently trained to deliver appropriate and safe care and treatment to people using the service.

The Mental Capacity Act 2005 (MCA 2005) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a person's best interests. Some efforts had been made by staff to work within the principles of the MCA but the record keeping was not always accurate. They had requested capacity assessments and a best interest meeting had been arranged.

Is the service caring?

Inadequate

The service was not caring.

People we spoke with told us staff were kind and comments about them were positive overall. We observed some staff spoke clearly when communicating with people and care was taken not to overload the person with too much information. This helped staff to build positive relationships with the people they were supporting. Some of the staff we spoke with told us of their commitment to provide a good standard of care.

Staff routines were mainly task focused. However, we noted some positive relationships between staff and those they were supporting.

Some people we met during the visit were dishevelled and attention was not given to people's fingernails and hair. We saw that men were unshaven and people were seen to have food stains on their clothing or around their mouths after meals.

Staff were reactive rather than proactive when issues arose, and did not always appreciate what contributed to good end of life care. Therefore service users were at risk of not receiving adequate and safe care, particularly when they were vulnerable or being nursed in bed.

Is the service responsive?

Inadequate

The service was not responsive.

People had not been involved in planning their care. Not all care plans and associated records were up to date and did not reflect the current care needs of some people.

People were given support to make a comment or complaint where they needed assistance. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints records; there had not been a formal complaint in the last twelve months.

The environment was in need of improvement particularly around the areas used by people living with dementia. For example, there was little useful signage or use of colour to help people orientate themselves when moving around the home. The home was dirty and there were malodours, some extremely strong, particularly in the large communal lounge and some bedrooms. There was little signage or other aids visible in the service which would benefit people who were living with dementia or had cognitive impairment.

Is the service well-led?

Inadequate

The service was not well-led.

Summary of findings

Paperwork and systems were disorganised and chaotic with files and papers randomly distributed in an ad hoc fashion, making it difficult to locate information quickly. There seemed to be little or no urgency to address matters, which staff acknowledged throughout our visit.

The home did not have an effective quality assurance system in place and there was no audit schedule. This meant people were not benefiting from a service that was continually looking at how it could improve.

There was no clear leadership in the home. The acting manager was unable to provide supervision or address issues as they arose, as the expectation was that the acting manager and the deputy worked on shift to provide care to people who used the service. There was no opportunity to work on a supernumerary basis to reflect and make any positive impact on the practices in the service.

The service had notified the Care Quality Commission, as required by law, about accidents and incidents since their last inspection.

Royd Hill Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection over two days, the 4 and 7 February 2015. On 4 February 2015, the inspection team consisted of two inspectors and a specialist advisor (with knowledge of complex care needs, tissue viability and end of life care.) The team were also joined by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector carried out the second visit on 7 February 2015.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority and looked at ten safeguarding alerts that had been made. In addition to this, before the inspection we would usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not request the PIR. However, this does not affect the inspection process, the information we requested can also be gathered during an inspection visit.

We used the Short Observational Framework for Inspection (SOFI) because there were a number of people living with dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed people in the lounge and dining areas during meals and at rest.

On the 4 February 2015, we spoke with five people who could share their experiences, two visiting relatives and nine members of staff. We tracked five peoples care from when they were admitted and looked at how their present needs were being met. We also spoke with the operations manager and area manager for the service.

We looked at all areas of the home, including people's bedrooms with their permission. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, maintenance records, staff duty rosters and staff recruitment files. We also observed a medication round in the morning, the lunchtime experience and interactions between staff and people living at Royd Hill Nursing Home.

Inadequate

Is the service safe?

Our findings

The service was not safe.

During the inspection on 4 February 2015, we carried out an observation in the large communal lounge during the morning and at lunchtime. At the same time, observations were carried out in the communal dining room.

We saw examples where people were not receiving appropriate care. For example, we reviewed the care records for one person. The record stated that the person was at high risk of developing pressure ulcers, was using a specialist mattress on their bed but spent most of the day sitting in an easy chair in the lounge area. Whilst in the lounge, a pressure relieving cushion was being correctly used. We were told that this person had a repositioning chart but we found that this had not been completed. The National Institute for Health and Care Excellence guidelines recommend that people who are at risk of pressure ulcer development should not spend more than two hours in a chair without repositioning. During the visit on 4 February 2015, we saw no evidence of repositioning whilst the person was sat in the chair in the communal lounge. Therefore staff were not following nationally recognised guidance to ensure they met this person's needs placing them at risk of harm.

In addition, people being nursed in bed were not being repositioned according to their needs. For example one person who had been assessed by the nurses and required two hourly 'turns' to prevent pressure ulcers was being left for long periods in between turns. For example, on 1 February 2015, a person who required a change of position at two hourly intervals had been left for three and a half and four hours on three separate occasions without changing position. This meant that the person was at greater risk of developing pressure ulcers and being uncomfortable. In addition, time spent repositioning someone can also be an opportunity to check the person is not in pain or requires additional support with drinks or food provision.

A visiting nurse practitioner, from the community nursing team, raised concerns about one person, who should have their drinks thickened to prevent choking. The person had a drink, that had not been thickened as required, within easy reach which could be taken without staff knowledge, therefore putting them at risk of aspiration. The nurse practitioner also informed us that another person was to be seen by the doctor as they had shown signs of dehydration. A safeguarding alert had been made to North Yorkshire County Council by the nurse practitioner, on the same day, due to the risks posed.

At 12.30 there were five people seated in easy chairs in the large lounge. Each person had an over-bed table in front of them. The inspector was told that everyone was waiting to be served lunch and that those present all needed support from staff to eat and drink.

During the service of meals a member of staff noted that one person needed to be taken to the bathroom to receive personal care. The inspector witnessed two underarm lifting techniques used by staff, which are unsuitable lifts. These unsuitable lifts were being used to transfer the person from an easy chair to a wheelchair and back again. The inspector discreetly asked the staff present why this manoeuvre had been used. The staff told the inspector that the person could usually stand unaided but that she was 'not herself and hadn't been walking or standing without help for several days.' This was taken up with the deputy manager, who told the inspector that staff should use a 'lifting belt' where they needed to assist a person who could not stand without assistance. The inspector described the underarm lifts she had witnessed and the deputy manager spoke with staff immediately. Underarm lifts are dangerous when assisting people and put people at risk of harm and injury. Alternative techniques should be used, including the use of hoists and lifting aids.

It was also of concern that when we asked the care assistants about their general understanding of service user's care needs, how long people had lived at the service and their background they were unable to give us details. Whilst this in itself does not necessarily mean service users were not being supported, it gives cause for concern that staff with direct caring responsibilities did not have a basic understanding of the people they were employed to care for. This meant that proper steps were not being taken to ensure that people were protected against the risk of receiving treatment and care that was inappropriate or unsafe as staff did not know peoples individual needs.

We observed one person stand up from their chair and a blanket, which had been over their knees, slipped off and fell near their feet onto the floor. The care assistant, who was sitting in the lounge, called to the person 'watch the

Is the service safe?

blanket' but did not make any attempt to get up and move the blanket. This was done by one of the inspection team as they feared for the person's safety and thought they might fall. They were at risk of a potential injury.

A relative told us, "They [staff] seem to be able to calm her [my relative] down here; I know she falls a lot but it isn't their fault. I don't see [relative]'s falls mean that it is unsafe." However, another relative said they were concerned about the number of falls their relative had had.

The inspection team noted that people's needs were not anticipated or dealt with at the time they occurred. During a three hour observation session on 4 February 2015, in the communal lounge area, none of the people requiring support with their personal care were asked if they could be assisted to the toilet or be made more comfortable. One person was seen to have a full catheter bag, but none of the staff on duty had noticed this or offered to support them to the bathroom to have this attended to. This was immediately brought to the attention of the deputy manager, who dealt with the matter. This placed service users at risk of inappropriate care, including infections and not having their dignity respected.

The registered person had not taken proper steps to ensure that people were protected against the risk of receiving care or treatment that was inappropriate or unsafe because people's needs were not being met; inappropriate lifts were being used when moving people and staff were seen to ignore care needs as they arose. This is a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010

Three separate members of staff had been involved in the unsuitable lifting. According to the training matrix one of the members of staff had not received moving and handling training since May 2013, another member of staff had been trained in November 2011 and the third member of staff had not received any training at all in the subject. Staff did not have the required knowledge and skills to support people safely in this area.

The expert by experience spent time in the communal lounge areas observing between 10am and 11am. During that time the care assistants on duty were busy elsewhere in the home, which left the overseeing of the lounge area to the activity organiser. The activity organiser had not received training in dementia awareness, first aid, challenging behaviour, diabetes, nutrition and hydration, continence, palliative care or fire procedures. These are all topics which someone supervising people living with dementia could be expected to be trained in, in order to know when to call for assistance or respond to a person's distress or demeanour. The member of staff confirmed that they were 'left to do quite a lot of caring duties such as getting residents drinks, making sure they do not try to get out of chairs and generally overseeing their safety.' This meant proper steps were not being taken to ensure that people were protected against the risks of inappropriate or unsafe care. This placed people at risk of harm.

The registered person did not have suitable arrangements in place to ensure that persons employed were appropriately supported to allow them to deliver safe care and to an appropriate standard because of the lack of training, professional development, supervision and appraisal.

This is a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010

We walked around the premises and checked the records relating to cleaning schedules and audits. We found multiple examples of inadequate cleaning and poor standards of maintenance and décor. For example, chairs, walls, door architrave and carpets were stained and marked. There was a strong unpleasant smell of urine, particularly in the communal lounge area and the ground floor corridor. We noted that pull cords in toilets were dirty, some were covered in faeces and radiators were rusty and stained. Wheelchairs were stained with food waste and spilt drinks and easy chairs had torn upholstery and stained cushions. We found that crockery and cutlery cupboards were stained with chipped delaminated exposed areas, making adequate cleaning difficult. Some curtains and wall coverings were stained with food and in some cases bodily fluids. The kitchen area, despite being awarded a five star rating in 2014, was found to be dirty. Freezers, fridges and the floor were dirty and we found food debris under the sink area and waste bins that were overflowing.

Cleaning records were being kept until the 11 January 2015. There was no evidence in the cleaning file that cleaning had been carried out after this date and there were no cleaning schedules in place for the cleaning of equipment e.g. wheelchairs. Equipment should be cleaned after use and the member of staff cleaning it should record the date it was cleaned.

Inadequate

Is the service safe?

We found that there were inadequate levels of cleanliness and the home was not following the Code of Practice on the Prevention and Control of Infections and related guidance ('the code').

A mattress audit had been carried out on the 29 November 2014 and all mattresses had passed the audit except one. We could not check whether a replacement mattress had been purchased because the person was in bed during the inspection and staff could not confirm if this had been dealt with. The cleaning routines and methods outlined in the services policy were not being carried out. For example it was recorded that carpets should be cleaned every six months but there was no evidence to support that this happened.

In the basement area, the corridor was dark and this made it difficult for people with a visual or perception impairment to navigate to the different rooms. One mattress was stained but still in use, the bedroom also had staining to the walls. The toilet and shower room in the basement was heavily stained and was malodourous. There was accumulated dirt on the wheelbase of the hoist and commodes were stained. The battery operated door mechanisms on two doors, which are linked to the fire safety system meaning they would automatically close should the fire alarm go off, were bleeping continually indicating they were in need of new batteries. The annoying noise was continual and it was unclear whether the device would be effective should a fire occur as they needed new batteries. It was not until a second monitoring visit to the Home on 7 February 2015, three days later, that the batteries were eventually changed. This means there was a risk of the fire doors not closing if a fire should occur and that people using this area for sleeping and relaxation may have been disturbed by the continual bleeping. In contrast some bedrooms were personalised and people had their own furniture or cherished items with them, which they said made them feel at home.

The fire safety officer had made a visit to the service on 3 February 2015 and at the time of the inspection the home was waiting for a report from that visit. We received a copy of the report on 13 February 2015. The report stated that after the audit of fire safety that the home was considered 'unsatisfactory.' Concerns were highlighted by the fire authority about the lack of a suitable and sufficient risk assessment for the premises, that in the event of danger persons would be unable to evacuate the premises as quickly and as safely as possible and that appropriate procedures and safety drills were not established. There was also a concern in the report about inadequate training for staff. On receipt of the report we contacted the provider and the operations manager. They had not received the fire safety officers report but we were able to forward this to them. We were informed that a fire drill had been completed in December 2014, and that another fire drill was due to take place to include new staff and to make sure bank staff were familiar with the procedure. However, no action had been taken to address the other matters highlighted by the fire officer.

On 4 February 2015, the laundry assistant was absent from work and care assistants were dealing with the laundry. Care assistants were seen to deal with the dirty laundry without protective aprons and then leave the laundry area to serve drinks to people in the same uniform they wore to deal with soiled linen.

Laundered clean clothes were stored in the laundry room on open shelves – clean clothes should not be stored in the laundry room, if no additional space is available good practice recommends that clothing is stored in a cupboard with doors to prevent contamination. Pillows and sheets were also stored in a cupboard which was open and therefore there was a further risk that clean linen could be contaminated as it was not protected from the dirty linen being brought into this area.

We concluded that the premises were unhygienic and systems and procedures were not being followed to provide a safe and clean environment. This is a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010

The staffing arrangements at Royd Hill Nursing Home allowed for at least one qualified nurse at all times. The nurse was supported by four care assistants plus a team leader from 8am until 2pm and three care assistants from 2pm until 8pm. The staffing remained at three care assistants during the night shift, with one qualified nurse. We were told by the operations manager there was a vacancy for a nurse for some of the night shifts and that they were busy trying to recruit. The shortfall was being made up by the use of bank staff and the acting manager and the deputy manager, both newly appointed, had to

Is the service safe?

work extended hours and long days to cover the short fall in nursing shifts. This meant they could not carry out their acting manager and deputy roles because they were being counted on the roster as 'hands on nurses.'

Safe recruitment practices were followed to ensure that people were suitable to work at this setting. We examined three staff recruitment files and saw that appropriate checks had been made to determine whether or not people were suitable to work at this service. People had been checked through the Disclosure and Barring service to check if they had a criminal record and had two references to check their suitability to work in a care setting. If any matters had arisen and needed clarification, the registered manager had followed up the information and recorded this on the staff record.

It became apparent during the second day of inspection, on the 7 February 2014, that the two nurses were not going to continue their employment at the service. One nurse completed a resignation letter at the time of the inspection and the other nurse told us that she was also leaving with immediate effect. This was reported to the area manager, by the inspector on the day of the inspection as there was a concern that the home would not be covered by a qualified nurse. The area manager arranged for the shifts to be covered before the inspector left the home. The team of ancillary staff worked seven days, this included food provision and domestic roles.

We looked at how medicines were managed. We looked at how the service received, stored, administered, recorded and disposed of medicines. We also looked at how controlled drugs were managed. We joined a member of staff carrying out a medicine round to observe practice. The service had a medicines policy and procedure. We found that medicines management was well organised and people received their medication at the right time and in accordance with the prescriber's directions. We asked staff about how they managed medicines to be administered 'when required.' Staff were very clear about obtaining specific instructions from the prescriber and showed us evidence of when they had asked for clarity to make sure medication was given appropriately.

The records which confirmed the administration of medication or application of creams and other topical preparations were completed at the time medication was given by the member of staff carrying out the task. When we checked a random sample of medicines we found these matched the expected stock being held. People we spoke with told us they received their medication at a convenient time and did not have any problems getting their medication if it was for pain or discomfort.

Medication was being stored properly and records were kept of the fridge temperature being used to store medication, which had to be kept cool and maintained at less than 5 degree centigrade. This meant that medication was being stored as instructed by the manufacturer and safe to use.

Controlled drugs, which are medicines which may be liable to misuse, were being stored appropriately. We checked the records of their use and found the required documentation was being kept, that two staff were signing when the controlled drugs were being used and the stock matched the expected amount.

Staff were able to describe how they would identify and report abuse and knew how to alert the appropriate person if necessary. They described the different types of abuse and which situations would constitute abuse. We saw from the training records that the majority of staff had been trained in the safeguarding of vulnerable adults.

Inadequate

Is the service effective?

Our findings

The service was not effective.

We asked the area manager about the staff training provided to staff at the service. We saw that staff had received little training; according to the training matrix some staff had not received adequate training. Out of 29 staff only 18 had any training in pressure area care. This meant people were placed at risk of harm because the service had not taken steps which ensured staff had been trained to carry out pressure area care effectively or competently. Mandatory training had not been delivered to staff nor had other specific topics such as dealing with people who may exhibit challenging behaviour, palliative care and skin integrity. All these topics are relevant to the current population of people being cared for at the service. Some training dated back as far as 2012 and 2013. According to the information provided by the area manager, only the acting manager had received training around nutrition/hydration in November 2013. This meant that people were not being cared for and supported by a staff team who the provider could be confident were using current good practice and people were at risk of receiving unsafe and inappropriate care. This was a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010

We observed lunch being served in the communal dining room. Lunch service began at 12.30pm. Not everyone was seated in the dining room, five people were supported with their meals in the communal lounge and others were assisted in their own bedrooms.

Lunch was plated and served from the kitchen. Portions looked small and food looked bland and unappetising. One person was served a sausage, a small amount of mashed potatoes and peas, with watery gravy poured over it. The person told us they did not like sausages but had been told that 'was all that was left.' The person went on to say they 'didn't always enjoy the meals and that they didn't get enough to eat and drink.' All of the inspection team had noted during the visit that it was unusual to see how thin and frail everyone looked. Comments about the food were mixed, however it was evident from the food charts and the weight records reviewed that some people were losing weight and no appropriate remedial action was being taken. One person told us, "There are no choices, I don't get thirsty, I get hungry when it is time for bed, I don't get anything offered to me." Other comments included, "The food is OK; usually don't have a lot of choice" and, "Depends, its good value and eatable. I accept what they put in front of me." One person told us, "I can't grumble about it. If they gave me something I didn't like, I would put up with it and not ask for something different."

We asked staff about the availability of food and drinks outside the scheduled mealtimes. Staff told us that drinks were taken round during the morning and afternoon and that people could have a hot drink and sandwich at supper time if they requested it. There was no assurance that those who could not request additional food and drinks were offered any snacks.

During lunchtime in the communal dining room, we saw one person had fallen asleep with their head over their plate of food. The person had not eaten anything. There was only one care assistant overseeing the dining room and she was assisting another person on the same table with their meal. We saw that it was 20 minutes before the care assistant noticed the person was asleep and woke them to ask if they wanted their meal warming up. The person answered no, the care assistant walked away and they started to eat. They ate very little and fell asleep again, this time with their face nearly in the food. This was not noticed by the care assistant and the plate was taken away, with the person having eaten very little. The person presented as needing support and encouragement to eat but none was given.

We also observed another person being assisted to eat their meal, the manner of the care assistant was impersonal with little interaction and time being spent to make sure the person had a pleasurable and social experience. There was no interaction regarding the food being offered or any regard to the pace at which the meal was being given. Desserts were put down in front of people with no interaction between the person being served and the care assistant. None of the people eating were offered second helpings, even if they had finished their plate of food.

Another member of the inspection team sat in the communal lounge observing people being supported to eat their meals whilst sitting in their easy chairs with an over bed table pushed up to them. Again the lunchtime experience was impersonal and lacked socialisation.

Inadequate

Is the service effective?

We reviewed two care plans relating to people who had lost weight. Despite the weight loss being recorded, there had been no referral to the dietician and no further action had been taken to manage the weight loss. We would have expected that the two people were weighed weekly, and action be taken to address their individual weight loss.

We talked to the cook, about specialist diets, including enriching food for those needing a high calorific diet and how individual tastes and preferences were catered for. The cook had little knowledge about specialist diets and could not give an account about how additional nutrition was provided for those at risk of malnutrition. Despite the operations manager telling inspectors there were problems with the provision of food, no action had been taken to address the situation therefore leaving people at continued risk of not being provided with an adequate diet.

The failure of the registered person to protect people from the risks of inadequate nutrition and dehydration, the lack of choice available and the lack of support necessary for people to eat and drink sufficient amounts for their needs. This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010

We spoke with two visitors who told us that they were pleased with the care their relatives were receiving. However, on 11 February 2015 the Commission received anonymous information from a concerned person. They told us, 'Care was appalling to say the least. [Person] was dirty and unkempt, had lost weight. Significant amount of bruising noted which was unexplainable. People not kept safe. Major concerns for the residents that are in the Home. They should not be allowed to get away with this lack of care.' This information has been shared with the local authority safeguarding team, who were aware of the concerns and incidents involving the person's relative.

The Mental Capacity Act 2005 (MCA 2005) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a person's best interests. We saw that records varied but that some attempts had been made for those who were unable to consent to care and treatment. To adhere to the principles of the MCA, a best interest meeting had been held. Where necessary others had been referred to the local authority to request a capacity assessment. This told us staff were working within the principles of the MCA 2005 to empower people to make decisions for themselves and recording some of those decisions. Eleven staff had received training around this topic and we were told by the area manager that they were responsible for cascading the information to the staff team and took the lead when issues arose.

Inadequate

Is the service caring?

Our findings

The service was not caring.

We looked at the care records for two people who were receiving palliative care. Palliative care is the active holistic care of people with advanced progressive illnesses. This care includes the management of pain and other symptoms and the provision of psychological, social and spiritual support. People receiving palliative care can have complex needs and require extensive support to be comfortable and pain free. People receiving palliative care can also be at risk of dehydration and malnutrition if they need regular support to eat and drink.

We noted that one person, who was being nursed in bed had a pressure ulcer on their ear lobe which had not been picked up by staff and needed to be dressed and documented. Only one of the three care assistants on duty had received 'pressure care' training and once alerted a nurse on duty attended to the ulcer. We concluded that staff were reactive rather than proactive when issues arose, and did not always appreciate what contributed to good end of life care. Therefore service users were at risk of not receiving adequate and safe care, particularly when they were vulnerable or being nursed in bed.

We visited both people in their bedrooms. One person was very poorly and was found to be unresponsive to conversation. They were being nursed in bed. We looked at the last four charts in use and saw that they were hard to follow and there were gaps in the recording. One chart started on 12 January 2015 and detailed the food that had been offered and taken at each mealtime and when snacks were tolerated between meals. However, the other three charts were undated and staff could not account for how much food or drink the person had taken. When drinks were not being taken there was no evidence that the persons lips were being moistened or that they were being given any mouth care.

Appropriate steps were not being taken to make sure staff carried out their roles and responsibilities to ensure the welfare and safety of individuals. During our observations in the communal area a person was seen to pull their clothing up and expose their thighs and underwear. Despite the persons dignity and privacy being compromised, staff in the area, having seen the incident did nothing to support the person to cover themselves or offer a blanket. Which gave the impression that people's dignity and privacy was not of importance to staff.

We noted that a significant number of service users were unkempt and dishevelled in terms of their personal appearance. For example, people were seen to have long fingernails with dirt underneath, people's hair was not groomed, looked greasy and unwashed and men were unshaven. After breakfast and lunch, we noted that some people were supported back to the lounge area and they had food stains on their clothing, people had food on their hands and dried food around their mouths. Staff did not attend to this detail which compromised peoples overall dignity and respect. This lack of attention to detail and fundamental care was indicative of a service where people were not given basic care, thus placing them at risk of infection and neglecting their welfare and wellbeing. These were breaches of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010

We did not see any referrals or the involvement of advocates recorded in care records. There was no information displayed informing people of these services.

We asked people if they could make choices about their daily lives, for example, what time they got up, went to bed, and had a shower or bath. Everyone we spoke with told us that they did not have any choices regarding these matters. Comments they made included, "Sometimes I think my dignity has been taken away." And, "You have to wait until they get you out of bed. It is early when they get me up. They take me to bed when they think it is time." One person told us, "They tell me when it is shower day. They choose my clothes." And "I would like a shower every day but you only get one once in a blue moon." We concluded that routines were designed around the staffing arrangements and for the convenience of staff and not at the choice of those receiving support and care.

The registered person had not taken proper steps to ensure that people were protected against the risk of receiving care or treatment that was inappropriate or unsafe because people's needs were not being met. This is a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010

We noted that one person had a pre-existing condition and had also started to refuse meals in December 2014. There

was no evidence of any referral to other health care professionals, particularly the mental health team to address the persons failing health. It was accepted by staff that the person had stopped eating and drinking, without seeking expert advice about how best to support the person. It was only after the person had been seen by his doctor, who diagnosed dehydration that fluids were provided using a subcutaneous injection. (This is where fluids are given into the layer of skin directly below the dermis and epidermis, collectively referred to as the cutis.)

The second person had been 'independent with eating and drinking and usually has a good appetite until their weight had started to decrease in January 2015. Action had been taken and a '1st line care plan, 3 day food and fluid chart and 24 hour fluid chart commenced.' However, there was a delay in the records being completed and action being taken which resulted in the notes stating, '[Named person] had not had the sufficient amount of fluid and has been put on subcut fluid.' The last time the person had been weighed was early January 2015; no further weights were recorded for the remainder of January 2015. This meant that staff could not assess whether the person was continuing to lose weight or was gaining weight. This placed the person at risk of harm because staff could not seek advice from other health care professionals where weight loss occurred.

Records of fluid and food intake were found to be contradictory and incomplete. For example charts showing food intake, which also included fluids, showed different totals to those recorded on the fluid only charts. It was unclear whether both charts were in use on any particular date or if the amounts were separate and therefore needed to be added together to give a true account of the fluid each person had taken. Had the forms been reviewed this duplication of information or inaccurate recording would have been noted. The way the records were being completed made it impossible for staff to accurately monitor intake and therefore they could not be confident they were providing the appropriate support.

We reviewed the fluid balance chart for another person. According to the fluid balance chart the person had had 115mls of fluid in twenty-four hours. Nursing guidance states that one litre of fluid should be taken in any twenty four hours. Therefore this person was at serious risk of dehydration, as they had received only a tenth of the recommended clinical intake. In addition to this the person had a catheter, and insufficient fluids can put them at an increased risk of infection if they do not drink enough. Fluids help to keep the urine flowing and therefore debris does not build up and cause a blockage. There is also a risk that bacteria can track back into the bladder, which also places the person at risk of an infection. This placed people at risk of harm.

One person had lost 41% of their total body weight in twelve months. According to the care records reviewed we concluded that the person had received poor nutrition, inadequate fluid intake, had had a significant weight loss, was at high risk for potential urine infections, and pressure ulcer development. This was because there was no clear strategy for pressure ulcer prevention or the best way to meet this person's needs.

We also reviewed the nutritional risk assessments in place for other people who had lost weight. The policy in the Home is to weigh people monthly and people who are losing weight have their food intake monitored using a food chart; the person should be prescribed nutritional supplements if appropriate and referred to the Dietician. We saw that referrals were being made to the dietician appropriately however, there was no verbal or written evidence to show anyone had actually been reviewed or seen by a dietician, or that the dietician had visited the service. Therefore there was strong evidence that suitable arrangements were not in place to make sure other health care professionals, particularly dieticians were involved in people's care therefore preventing them from receiving expert advice and putting them at further risk of malnutrition.

The failure of the registered person to protect people from the risks of inadequate nutrition and dehydration, the lack of choice available and the lack of support necessary for people to eat and drink sufficient amounts for their needs. This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010

People we spoke with could not recall having had any involvement with the writing of their care plan or the decisions about their care needs going forward. However, we did note that some staff and people they were supporting had a good rapport and knew each other well.

Overall, relatives we spoke with made positive comments about the care provided. People were supported to maintain relationships with their family. One visitor told us,

Inadequate

Is the service caring?

"I have looked after [named] for a few years and I think the care she gets here is very very good. If there are any concerns they would tell me. The staff are very good to get on with." Another relative told us, "Staff always seem very caring with her. I have never noticed any staff being abrupt to anyone. Overall, perfect, I cannot fault it."

Some people who had complex needs were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found some people responded in a positive way to staff in their gestures and facial expressions. We noted a range of interactions between staff and people using the service. Some interactions could have been handled better, for example during the dining room experience, being supported to use the toilet or assistance with personal grooming. We did however note that some staff knocked on people's doors before entering their bedrooms.

We observed some staff spoke clearly when communicating with people and care was taken not to overload the person with too much information. This helped staff to build positive relationships with the people they were supporting. Some staff were able to give us examples of how people communicated their needs and feelings. Some of the staff we spoke with told us of their commitment to provide a good standard of care. Some staff acknowledged that they were finding it hard to provide the care they wanted to provide and that some of the staff 'don't get on.' Some staff became emotional when talking about their work and that they found it hard when not all the staff were working together to improve the service and not doing the right things for example, not completing care records or treating people properly. This they told us was frustrating when they themselves were trying their utmost to make sure people were cared for properly.

The majority of people we spoke with during the visit told us they were generally happy with the number of staff on duty and that they could not recall having to wait for attention if they needed it. However, one person did say, "If I press my call bell they would come but I don't know about coming quickly, they take their time." We tested the call bell during the course of our visit and all were answered promptly.

Some people we spoke with said they were happy with the care provided. Comments included:

"I just tell them and they look after me." One person talked about the staff and told us, "She looks after me and reminds you things I need to remember." Another person told us, "If anything is wrong, I tell them, they listen to me." One person commented, "Yes they are nice to me, they seem to know me." And, "They are very polite. I have never heard staff ever get annoyed with people. They are always helpful and have a good attitude." However, there were other views expressed, "Yes mostly good but they don't always realise what I can't do, I can't even stand up without help let alone walk." Another person told us, "I don't think they always understand my worries." One person summed up their view saying, "Sometimes it's marvellous, sometimes its crap." One person told us, "They haven't time to talk to people."

Inadequate

Is the service responsive?

Our findings

The service was not responsive.

Many of the service users at the Home have some cognitive impairment and some have a diagnosis of dementia. It is expected that where people re supported around their dementia care needs that a service would provide adequate and appropriate signage to enable people to access areas more easily. It is also required that the use of colour and equipment is provided to enable people to move around safely.

We noted that signage was poor throughout the home, for example other than one picture image on a toilet door; it was not clear where toilets and bathrooms were or where people could find a dining area or lounge. The doors to all of the bedrooms, bathrooms and toilets were the same colour. Few bedroom doors had people's names on them or a photograph or memorable item to remind people which their bedroom was. This meant people living with dementia had to be taken to their bedrooms and toilet. However, if the signage had been clearer, they would have been able to access to these areas more independently. This meant people's privacy and dignity was not always being respected and their needs not met in relation to their environment

Toilets were all one colour and did not have toilet seats in a contrasting colour. This would make it difficult for people with visual or perception impairments to differentiate between them when using the toilet. Food was served on white plates, for some people living with dementia, food such as potatoes can be difficult to see when served on a white plate. These are all aids to support people in a person centred way and no recognition or acknowledgement had been given to providing these facilities.

We overheard a person tell a care assistant that they were in pain and that their leg was hurting. The care assistant replied and said she would get a nurse to come. However, the care assistant made no attempt to go and find the nurse at that time, even though the person kept repeating they were in pain. This lack of attention by the member of staff was an example of failure to respond to peoples immediate needs.

The registered person had not taken proper steps to ensure that people were protected against the risks of receiving care and treatment that was inappropriate or unsafe because the delivery of care did not meet individual's needs. This is a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010

Records relating to the care of people were not being completed accurately or in a timely way. For example, care plans were not being reviewed on a regular basis or when they were reviewed did not reflect the up to date information relating to a person's condition, for example, mobility. On the inspection on 7 February 2015, we noted that a person needed to have their position changed every two hours. The pressure area charts were examined for 4th, 5th, 6th and 7th February 2015, up to 9am. There were some occasions when the changes to position had not been completed two hourly, for example, three hours had lapsed before turns were carried out. On the chart for 6 February 2015 the person had been left for up to three and a quarter hours before staff moved them and this had happened on two occasions. It was also of concern that at 10.45am, the record for repositioning at 9am showed that the person was on their 'right' side when in fact they were on their 'left side' in bed. When asked if the person could have moved over without assistant the member of staff said they could not. Therefore the last entry on the record, which was the last time the person had been repositioned, was inaccurate. This lack of accurate detail meant that staff could not say with confidence what care the person had received.

During the inspection we looked at the 'behaviour charts' for three people. These charts are used to monitor people's behaviour and identify triggers and ways of responding to each person to support their needs. There was no evidence to show that the completed charts had been audited or used as a learning tool to understand and manage people's individual behaviours. For example, one person's behaviour had been labelled as 'attention seeking' but no referral had been made to any other health professional to establish why the person was behaving in the way they were and it appeared from the records seen that this was a term used by staff rather than a clinical diagnosis. This meant the staff did not have a plan of how to deal with the behaviours in a way that maintained the persons' dignity, health or wellbeing.

Assessments referring to moving and handling were not up to date and therefore did not reflect the needs of people.

Inadequate

Is the service responsive?

This meant that staff could be providing inappropriate support if they were following incorrect records to direct their care delivery and thus place people at risk of unsafe care.

Much of the information we looked at, for example in the daily notes, showed nothing other than if a person was asleep or awake with no indication of any meaningful engagement or social activity. We asked staff if there were any other records which had not been seen and staff told us there were none. This is a breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010

The operations manager told us people were given support to make a comment or complaint where they needed assistance. They said people's complaints were fully investigated and resolved where possible to their satisfaction. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints records; however there had not been a formal complaint in the last twelve months. People we spoke with said they felt able to raise any concerns or complaints with staff but were not aware of the formal complaints procedure.

Inadequate

Is the service well-led?

Our findings

The service was not well led.

There was no clear leadership in the home. The acting manager was unable to provide supervision or address issues as they arose, as the expectation was that the acting manager and the deputy worked on shift to provide care to people who used the service. There was no opportunity to work on a supernumerary basis to reflect and make any positive impact on the practices in the service. Staff gave mixed views about the management support they received. One member of staff felt very supported to do their work and felt valued as a team member. Other staff felt there had been a lot of changes in the senior team and there had been a period of unrest.

When we inspected this service on 4 February 2015, we found there was no programme of auditing and monitoring in order to maintain safety within the environment or care delivery to ensure people were safe. We asked the operations manager about this and they told us that this had been overlooked as the priority had been given to the delivery of care and not auditing. The acting manager also confirmed that they would not have had time to carry out any audits as they was not given supernumerary hours to undertake the 'managers role.'

There were ongoing safeguarding investigations being undertaken by the local authority at the time of our visit and these dated back to early November 2014. The lack of monitoring placed people at risk because staff were unable to pick up on issues effectively or promptly therefore when issues came to light harm or incidents had already happened.

There was no schedule of auditing in areas which impacted on people's care and wellbeing such as the environment and infection control, care plans and medication. Those that had been completed were out of date and no action or action plans had been completed. This meant that issues around safety and health were not being identified and followed up as a way to improve the service for people. For example, we found shortfalls in the recording of care, action being taken to address health related matters and no evidence that the quality or standard of cleaning in the home was being regularly monitored. From the evidence seen and conversations with the operations manager, it was evident that there was no clear strategy or strong leadership in the service. There were blank auditing documents which had been put in place but not yet completed.

This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010.

During the course of the visit it was clear that paperwork and systems were disorganised and chaotic with files and papers randomly distributed in an ad hoc fashion, making it difficult to locate information quickly. There seemed to be little or no urgency to address matters, which staff acknowledged throughout our visit. This included all designations of staff who told us there had been 'no surprises' when we fed back our main concerns at the end of the inspections. One member of staff told us the home was like a 'war zone' and that it felt 'dangerous.'

This is a breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010

Inspectors were told that staff supervisions were not taking place and that this was planned for the forthcoming month. Staff meetings were not being held but staff told us about the handover sessions that had recently started, which they found helpful. The lack of clear leadership, senior staff not providing front line management and no formal supervisions meant there were insufficient opportunities to ensure safe care was being delivered and gave little confidence in any improvements being made. This is a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010

The service had notified the Care Quality Commission, as required by law, about accidents and incidents since their last inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were not protected against the risks of receiving care and treatment that was inappropriate or unsafe because the registered person had not taken proper steps to carry out an assessment of the needs of the service user; and the planning and delivery of care did not meet the service user's individual needs or ensure their welfare and safety.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **People were not protected because the provider did not have an effective operation of systems designed to regularly assess and monitor the quality of the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **People were not protected against the risks of acquiring an infection as the maintenance of appropriate standards of cleanliness and hygiene were not met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person was not protecting people from the risks of inadequate nutrition and dehydration because people were not given appropriate assistance and help to each a nutritious diet and at regular intervals.**

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person was not protecting people from the risk of unsafe or inappropriate care and treatment because accurate records and documents were not being maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure persons employed were appropriately trained, supervised and appraised.