Ryecroft Care Limited

Ryecroft Private Residential Care Home

Inspection report

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Ratings

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

Overall summary

At our last inspection in December 2014, we identified breaches of legal requirements. We issued the provider with three warning notices in relation to these breaches. The breaches related to Regulation 9, care and welfare; Regulation 13, the management of medicines and Regulation 21 requirements relating to workers, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The warning notices advised the provider that further enforcement action would be taken unless they complied with the requirements of the regulations by the 27 February 2015.

We undertook this comprehensive inspection on the 09 and 11 March 2015. Our inspection visit was unannounced. During this visit we followed up the

Summary of findings

breaches identified during the December inspection. We found the provider had not taken appropriate action and the Regulations 9 and 13 had still not been complied with.

Ryecroft Private Residential Home provides residential care for up to a maximum of fourteen people. Bedrooms are single occupancy and people are provided with support in respect of their personal care.

There was no registered manager of the home at the time of our inspection. 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.'

During this inspection, we found breaches of Regulations 9,10,11,12,13,15,16,18,20,22,23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulations 9,11,12,13,15,17,18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches are being followed up and we will report on any action when it is complete.

We found similar concerns to those we identified at our last visit with regards to the management of medicines at the home. Storage, administration and record keeping was poor and unsafe in respect of medicines and people did not always receive the medications prescribed for them. This placed people at risk of harm.

Although people said they felt safe with staff and their relatives confirmed this, the provider and staff had a limited understanding of safeguarding and how to respond appropriately to allegations of abuse. We found three incidences where the provider had not responded appropriately to allegations of abuse. This meant people were not safeguarded against the risk of abuse.

Accidents and incidents were not properly recorded or monitored to ensure that appropriate action was taken to prevent further incidences. Where people had repeated falls, no professional advice had been sought so that the person received appropriate support. Staff had not been trained in safe moving and handling techniques and lacked the moving and handling equipment to meet people's mobility needs safely.

People and their relatives told us the home was short staffed. Staff confirmed this and we saw that staff were too busy tending to people's personal care needs to interact socially with people to ensure their well-being. Staff were working excessive hours without a day off, some staff had gone off poorly with physical exhaustion and agency staff were used at night as the provider did not have sufficient staff to cover the night shifts. This placed people's health, welfare and safety at significant risk.

Prior to our visit the Local Authority had alerted us to concerns about the safety of the premises and its equipment. We found these concerns to be warranted during our visit. Electrical faults, heating systems, emergency pull cords and bath hoists were all faulty and we noted a number of other concerns with the interior of the home.

The cleanliness of the home was poor. The kitchen and its facilities were dirty, and some food in the kitchen had either been opened but not dated or was out of date. This meant there was a risk it was unsafe to use. There were no consistent cleaning routines in place and no cleaning audits had been undertaken to ensure that satisfactory standards of cleanliness and infection control were being maintained. We made a referral to Environmental Health following our visit.

At our previous inspection we found the provider's staff recruitment practices unsafe. During this inspection we found that adequate improvements had been made to comply with the regulation that had been previously breached. We did however raise some concerns with the provider about the quality of references that had been sought in relation to persons employed. We asked them to explore these in more detail.

Staff told us they did not feel supported by the providers. They said they had not been sufficiently trained and lacked the safety equipment to do their job. We saw from staff files, that staff had not received appropriate appraisals, supervision and training. Two new members of staff for instance had received no training in order to provide support to people safely.

The provider had not complied with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards in the delivery of care and had not ensured people consented to the care they received. Staff we spoke with had a

Summary of findings

limited understand of what was required and had not received any training. People's emotional needs were not appropriately assessed and the support provided adequately planned or delivered.

People received sufficient quantities of food and drink and had a choice in the meals that they received. Their satisfaction with the menu options provided however had not been checked. Where people had special dietary requirements, the planning and delivery of care failed to provide sufficient information to ensure people's special nutritional needs were met.

Staff were observed to be caring, warm and positive in their interactions with people who lived at the home but had little time to chat to people. People's privacy and dignity needs however were not always met in the delivery of care. For example, people's confidential information in relation to prescribed creams and their application were visibly displayed in people's bedrooms for visitors to the home to see. We had discussed removing these items at the last inspection, but the provider failed to do this. People were unable to have a proper bath or shower as there were no adequate facilities available to do this. Staff had to wash people using a bowl of water in their rooms.

There were no social activities provided for people at the home. One person told us "There is nothing to do and nowhere to go. It's a waiting room to die". Some people spent most of the time in their rooms or sat silently in the communal lounge all day.

Care records were poor and did not adequately assess people's needs or risks. Care records were not up to date and people's care had not been reviewed for some time. Dementia care planning was poor and professional support for people's emotional needs had not been obtained. Professional advice and support for people's mobility and continence needs had also not been sought in some cases.

The service was not well led. The provider did not have effective systems in place to identify the risks to people's health, welfare and safety and failed to seek people's views on the quality of the service they received. The culture at the home was not open or transparent and staff were not supported or responded to appropriately by the provider. We discussed the issues we had identified at this inspection directly with the provider and expressed our concerns. We found a lack of accountability and responsibility by the provider in the acknowledgement of any of the concerns we raised.

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.

People's individual risks in the planning and delivery of care were not adequately identified, assessed and managed. This placed people at risk of inappropriate and unsafe care.

People were not protected from potential abuse as the provider and their staff had a limited understanding of safeguarding procedures. The provider had failed to appropriately safeguard three incidences of potential abuse.

Accident and incident records were poor and the provider had failed to seek appropriate advice and support where people had had repeated falls so that further falls could be prevented.

People, relatives and staff told us the home was short staffed. We saw from the provider's rota arrangements that staff were working excessive hours for long periods without rest days. Staff said they were exhausted.

Premises safety and cleanliness were poor and there were no health and safety or cleaning checks in place to ensure standards were maintained. We referred these issues to Environmental Health and the Health and Safety Executive.

Recruitment practices had improved. Appropriate references and criminal conviction checks for people commencing work at the home had been sought prior to appointment.

Is the service effective?

Inadequate

The service was not effective.

Records showed that staff had not received adequate and appropriate training and supervision in their job role. This meant they may not have had the right skills, knowledge and support to do their job effectively.

The provider had not compiled with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure people received appropriate mental health support and where enabled to participate in and consent to decisions about their care.

People were given enough to eat and drink and were given a choice of foods to eat. Planning for people's nutritional needs was poor and did not ensure where people had special nutritional needs these were met.

Care plans lacked sufficient up to date information about people's health related illnesses, the signs to spot in the event of ill health and the action to take.

Summary of findings

Is the service caring?

Requires Improvement

The service was not always caring and required improvement in some areas.

People and relatives spoke positively about the staff. Staff were kind and caring and people were relaxed and comfortable in their company. Staff had little time to socially interact with the people they supported as they were too busy tending to people's personal care.

People's privacy and dignity needs were not always respected and people's right to confidentiality was not protected. People were also not able to get a bath or shower due to a lack of adequate facilities.

Is the service responsive?

Inadequate

The service was not responsive.

There were no social activities on offer at the home and people often sat without any positive social interaction for long periods of time. This did not ensure people's social and emotional well-being.

Care records were poor and did not adequately assess people's needs or risks. Care records were not up to date and people's care had not been reviewed for some time. Care records required significant improvement.

Some people did not receive care that met their needs. For example, the home lacked adequately equipment to meet people's needs safely and provide appropriate care and people had not always been referred to other professional services when their needs required it. After our inspection we made safeguarding referrals to the Local Authority in respect of three people's care.

Is the service well-led?

Inadequate

The service was not well led.

There were no effective quality assurance systems in place to identify and manage the risks to people's health, safety and welfare. No adequate audits had been conducted in relation to care plans, health and safety, medication, accident/incidents or premises.

People's satisfaction with the service had not been sought through the use of satisfaction questionnaires and staff felt that staff concerns comments and suggestions about the service were not taken on board by the provider.

We discussed the issues identified at this inspection with the provider and expressed our concerns. The provider failed to take accountability or responsibility for any of the issues raised.

Ryecroft Private Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The way in which the inspection was conducted also corresponds to the new Health and Social Care 2008 (Regulated Activities) Regulations 2014 that came into force on the 1 April 2015

This inspection took place on 09 and 11 March 2015 and was unannounced. The inspection was carried out by an Adult Social Care (ASC) Inspection Manager and an ASC Inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. This included concerning information sent to us by the Local Authority.

During this inspection we spoke with seven people who lived at the home, two relatives, eight care staff, the provider, a healthcare professional, the Local Authority, the Environmental Health Services and the Health and Safety Executive.

We looked at the communal areas that people shared in the home and with their permission visited people's bedrooms. We also looked at a range of records including five care records, nine medication records, recruitment records for five members of staff, training records relating to the staff team, staff rotas, policies and procedures, records relating to health and safety and records relating to the quality checks undertaken by the service.

Inadequate

Is the service safe?

Our findings

We asked two people who lived in the home if they felt safe. One person said "I think so. I feel safe enough". The other person said "I don't know if I feel safe. Are you anywhere?" We spoke with two relatives and they told us that they thought that their relative was safe in the home.

We found that since our last inspection very few improvements had been made with regards to medicines and many of our concerns from our previous visit in December 2014 were still outstanding. Medicines were still not administered safely. The system in place to ensure that doses of medicines were not given too close together was ineffective and there was no way to know what the appropriate time was between each dose of medication. We found that medicines had been left in people's bedrooms and the people were not assessed to ensure they were safe and competent to administer their own medication.

We saw that some people were still not receiving their medicine in accordance with their prescription because they were asleep. This had not been reported to their GP and no action had been taken to ensure that the person was safe to miss their medication. We also had some concerns with the management and administration of controlled drugs in the home.

We found that the provider had not protected people against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. This was a further breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In discussions with staff they showed that they had limited understanding of safeguarding adults. Staff told us that if they had any concerns about potential abuse they would report it to the senior staff or the provider. In discussion with the provider they were unaware of their duty to notify potential safeguarding adult's incidents to CQC. We found three incidents of potential abuse that had not been notified accordingly.

We saw that an incident had occurred where there were considerable risks to the health and well-being of the person. This had been discussed with the person's GP. There was no care plan in place to support this person's behaviour and the incident had not been reported to the local authority safeguarding unit or notified to CQC. Appropriate action had not been taken to ensure that this person received adequate support.

These incidences were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not safeguarded against the risk of abuse as the provider had not responded appropriately to potential abuse.

We reviewed people's accident and incident records. We saw that there were three different sets of paperwork in use to record people's accidents and incidents. This made it impossible to track how many accidents/incidents each person had happen to them accurately so appropriate action could be taken. We saw that one person had fallen at least five times in the last five months. We asked a staff member if a referral to the falls prevention team had been made, we were told no referral had been made but that the person had some assistive technology in place to alert staff to when the person fell. This meant that no appropriate professional advice had been sought on how the home could minimise the risk of or prevent further falls.

Two people we spoke with told us the home was short staffed. One person told us they had been waiting all morning for their bed to be made. They said "Had a bad night, begging them to do my bed. Asking all morning". Another told us "Very short staffed at the moment. One of the girls did a night and day shift, then half a shift the next day. I've told (name) the girls are exhausted".

Relatives told us that at times they felt the home did not have enough staff. They said they had observed that staff were not always available when needed and that staff rushed around and appeared very busy. Staff told us that they did not have enough staff. They explained that staff absences were sometimes covered by agency staff but not always and that the agency sent different staff each time so there was no consistency. One staff member told us that two people who lived at the home had expressed a preference for female care staff to tend to their personal

care, but that the agency the provider used to cover night shifts, sent male carers. This was confirmed by a person who lived at the home who told us "Agency men at night. Coming in every night now".

We were told that one staff member had worked every day since mid-January and had not had a day off. We saw evidence that another staff member had worked 40 days in a row and had then gone off on sick leave with physical exhaustion. We received time sheet documentation from the provider that confirmed the hours that these staff had worked. We also saw that the rotas were only prepared a few days in advance because the home had limited staff so staff did not know in advance what they would be working.

These examples are breaches of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not always sufficient numbers of staff employed to safeguard the health, safety and welfare of people who lived at the home.

We were alerted by the Local Authority prior to our inspection that they had concerns about the safety of the premises. We found that these concerns were warranted during our inspection.

The staff told us that the electrics in the home kept "tripping out". Staff showed us that they had to crawl through a small opening under the stairs in the hall with a torch to reset the electrics. We looked at the electrical safety certificates and saw that a re-test had been required in August 2014. We shared our concerns with the provider. We were not presented with any evidence to show that this had been done.

We found that the temperature in the home was unbearably hot and this increased during the course of the day. Staff told us that the home was always this hot and that paramedics attended the home in January 2015 and expressed concerns about the heat in the home but nothing had been done.

We checked nine bedrooms and saw that emergency pull cords in seven of the bedrooms were either snapped or tied up. This meant people were unable to reach the cords to pull in the event of an emergency. We also saw that two people's bedrooms did not have any call bell system in place at all. This meant there was no way these people were able to call for assistance. We spoke to the provider about this as we were concerned about people's safety.

At our last inspection the provider assured us that the call bell system would be operational in all areas of the home and that staff would be provided with pagers so that they could see immediately which person was calling for help without having to go to the call bell alarm panel to find out. We found however that the call bell system was not operational on the top floor and staff had not been provided with the pagers.

Two bedrooms smelt offensively. Two people's ensuite bathrooms were used as storage areas which made them difficult and in one person's case, impossible to access. One person's bathroom was a mess with range of plastic bags, continence pads, medication basket with a variety of prescribed creams, vanity bags and a washing up bowl. The person's sink was also filthy. There was a lack of hand towels for people to use in both their own and communal bathrooms and people had been given toilet rolls to use in their rooms instead of hand tissues.

One person we spoke with had a bruise on their hand. We asked how they had got the bruise. They told us they had knocked their hand trying to turn on their bathroom light. When we looked, we saw that their bathroom light was situated behind their wardrobe. The person had to slide their hand between the wardrobe and the wall to turn on the light. Two bedrooms were also seen to have wires trailing from the person's television or radio which posed trip hazard to bot people and staff.

We asked to see the home's health and safety checks. We were given a copy of the provider's customer pathway checks. These checks were undertaken by the provider who, checked each area of the home for any hazards that may block a successful emergency evacuation. We saw that the last check was undertaken in February 2015 and that all areas had been ticked as satisfactory. We asked a senior member of staff about this and they told us that the provider "Had blinkers on" when they visited.

We saw that the provider completed a routine home check which internally inspected each area of the home for health and safety issues. The last inspection was completed over a year ago, in February 2014. There was no evidence a further or more recent inspection had been done. The home's

Inadequate

Is the service safe?

repairs action list had also not been fully completed, with outstanding issues relating to blocked drains and hazardous carpeting identified in areas of the home. This showed us that there was a lack of adequate maintenance of the home and failure by the provider to ensure that the home was safe for the people who lived there.

These examples were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 and Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people in the home were not protected against the risks associated with unsafe premises. We referred our findings to the Health and Safety Executive for investigation.

We looked at the cleanliness of the home and found that it was not up to standard. We saw that the kitchen, including the cooker was dirty and greasy. We found out of date food in the food stores and food left out uncovered. For example, nine loaves of bread had a best before date that was over a week old. We also noted that opened food had not been dated so it was unclear whether the food was still safe to eat. We looked in the fridge. We found that where items had spilled, spillages had not been wiped up and the fridge required a good clean. Some of the opened fruit juice drinks and condiments were out of date for example, an opened bottle of cranberry juice was dated best before January 2015, and a bottle of horseradish sauce was dated best before April 2014.

We saw that there was a cleaning schedule for the kitchen but there was no evidence to show that this had been followed. We asked about cleaning audits and were told that none were carried out.

We saw that lots of toilets and sinks around the home were dirty. We also saw that carpets were dirty and stained and some areas were held down with masking tape. The main toilet used by people who lived in the home was situated off the hallway in the home. We noted that this toilet was dirty. Staff told us that this toilet was difficult to flush so most of the people who used it could not flush it.

The home had an onsite laundry. We saw that the laundry door was unlocked. We found that there an open box of washing powder and other hazardous substances such as concentrated disinfectant and washroom cleaner, accessible to staff, visitors and people who lived at the home. Such items are classed as an 'irritant' by the Control of Hazardous Substance Regulations (COSHH) 2009. This placed people at risk of harm.

We also saw that the laundry had no facilities for example, hand soap, hand gels, or hand towels to enable staff to wash and dry their hands after handling soiled clothing. This meant staff operating the laundry had to come out of the laundry to use a communal toilet to wash their hands. There was also a lack of visible hand gels in use around the home. This meant there was a risk of cross infection.

These examples are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because standards of hygiene and cleanliness were not maintained. We referred our findings to Environmental Health for investigation.

At our previous inspection we had told the provider to make improvements to their processes with regards to recruiting new staff. At this inspection we found that appropriate checks including criminal checks were carried out prior to staff commencing work within the home. We looked at the recruitment files for three staff members and saw that the files contained all the documentation that was required. We did raise some concerns about the quality of the references that had been sought and suggested that the provider explore these in more detail.

The breaches identified are being followed up and we will report on any action when it is complete.

Inadequate

Is the service effective?

Our findings

We asked the people who lived in the home about the home. Comments we received included "I'm ok here. It's alright" and "I suppose I like it here. I don't dislike it." We spoke with two relatives who told us that they were happy with the care that their relative received but the staff were very busy and were always rushing around.

We asked the staff if they felt supported in their roles. They all spoke highly of the senior care staff but said that they did not feel supported by the providers. We looked at supervision records and saw that supervision rarely occurred and had been carried out by a number of different supervisors so there was no consistency. We also saw that most staff had not had an appraisal.

We asked the provider about staff training and they gave us a training matrix which showed that two new staff members had commenced work and had not completed the appropriate training. One staff member had been in post for two months and had not completed any training. We had significant concerns as these staff members were supporting people with all aspects of their care without any training in order to do so safely.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have suitable arrangements in place to support and train staff.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with staff and the providers of the service. Neither demonstrated a full understanding of what was required and staff had not completed appropriate training.

We reviewed people's care files. We saw that where people were noted as having dementia type conditions or lacking capacity, there was no evidence that the provider had followed the required legal processes to ensure people had given consent or participated in decisions in relation to their care. For example, we saw that one person's capacity had been assessed but the person's assessment was poor and relatively meaningless. The assessment had also not been reviewed since July 2014 which meant it was potentially out of date and inaccurate.

A staff member told us that the person had recently had a mental health assessment completed by the mental health team. There was no information in the person's care file to evidence this assessment or its outcome. There was also no evidence of any best interest decision making in relation to the person's care or evidence that everything practicable had been done to support the person to make or participate in decisions about their care. This meant that the principles of the MCA and the DoLS legislation had not been followed and people's human right to consent to their care had not been respected.

The provider told us that no one living in the home had a DoLS in place at the time of our inspection. They said however that an application had been made for one person living there. We found however that the provider had not followed the required legal processes in determining and agreeing the need for the person's DoLS prior to making an application to the Local Authority.

These examples are breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 and Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that there were suitable arrangements in place to enable people to participate in and consent to decisions about their care.

We saw that people had a choice to either eat their meals in the dining room or their bedrooms. The home operated on set mealtimes during the day and had a four week rolling menu from which people had two meal options to choose from. People had varied opinions about the amount and type of food they were offered and we saw little evidence that people's feedback on the menu options provided were gained to ensure they were happy with the choices.

Inadequate

Is the service effective?

We saw that there was a whiteboard situated outside the kitchen which identified each person and their food and drink preferences. The whiteboard also included details of who was on a special diet for example, a soft food or diabetic diet.

We reviewed the cares files of two people who were identified as having special dietary requirements in relation to a medical condition. We found a lack of any appropriate nutritional planning and information in relation to the person's dietary requirements and risks. This meant that there was a risk that people's nutritional and medical needs were not being met.

We did a tour of the premises during our visit. The home itself did not provide a dementia friendly environment. For example, signage throughout the building was small and above eye level, all of the bedrooms looked the same and environmental cues which help people with dementia to orientate themselves to their surroundings were poor. There was also no difference in colour or design between people's personal bedroom doors or bathroom doors to enable people with dementia to tell the difference.

Corridors in the home were narrow and difficult for wheelchair users to access and there were steep stairways up to the first and second floors which posed a hazard for people with mobility problems and other people at a high risk of falls for example people with dementia related conditions. We saw that there was a passenger lift at the home in use and we saw from care records that staff were instructed to advise people to use the lift rather than the stairs to reduce the risk of people falling.

The breaches identified are being followed up and we will report on any action when it is complete.

Requires Improvement

Is the service caring?

Our findings

We asked the people living in the home if the staff were caring. Most people responded positively about the staff. People's comments included "They (staff) do their best for us"; "Staff are very good" and "I don't dislike the staff but they never have time."

We observed the staff talking to and supporting the people who lived in the home. The staff were caring in their approach and appeared to have warm, positive relationships with the people that they were supporting. However we did see that staff did not have time to spend interacting with people as all their time was spent carrying out personal care for people.

We saw that one person was in a state of undress on the day of our visit and requesting to go to bed yet the person's door was wide open. This compromised the person's dignity. We saw that the person's bed had not been made and that their curtains did not close properly. Staff had used empty shampoo bottles to hold their curtains closed to try to protect their privacy. We found a lot of people's bedroom doors were open even if people were in bed asleep. This meant that visitors to the home could easily see people in their nightwear. This compromised their dignity and right to privacy.

We saw body map diagrams displayed visibly in three people's bedrooms. These diagrams had various parts of the person's body coloured in to show where prescribed cream was to be applied. This compromised the person's right to privacy and confidentiality in relation to their personal care. We had discussed removing these confidential care diagrams at our last inspection with the provider but no action had been taken.

One staff member told us that a person who had been end of life care had recently passed away. They said that they had come in to work on a voluntary basis during the night, so the person was not alone and to ensure they received all the care they needed. This demonstrated that staff had a caring attitude to the people they cared for. This was confirmed by one person at the home who told us "Care workers here are care workers inside".

We were told that one person at the home was currently involved with the NHS End of Life Care Team. When we asked whether staff had had received any training in end of life care, we were told no training had been given. This meant that there was a risk that staff did not have the right skills and knowledge to provide appropriate and safe support to people on end of life care.

Inadequate

Is the service responsive?

Our findings

We asked the people who lived in the home if they did any activities. They told us that there were no activities as the staff were too busy. One person said "There is nothing to do and nowhere to go. It's a waiting room to die." This person asked us what time it was and pointed out to us that the two clocks in the room were wrong. We told the person the time and they were confused about whether it was day or night time. We showed the clocks to a staff member and we noted that later that day one of the clocks was showing the correct time but the clock showing the wrong time was still in situ which may have caused further confusion.

We saw that two people spent most of their time in their bedroom. One person was unable to move independently and remained in their room 24 hours a day and night with little stimulation. The other person had no television, radio or other stimulation for example books in their room to occupy their time. We shared our concerns with the provider as we did not think that this was acceptable.

Some people spent time in the lounge area during the day but were sat most of the time in silence with the television on in the background. There was little conversation or social activity during lunchtime and staff were too busy tending to people's personal care needs to interact with people socially. One person told us that there used to be a staff member who used to "Do all sort of things; board games, events and other activities". They said this staff member had left and "No-one had picked it up". They told us that they did not bother going into the communal dining room for their lunch anymore as most of the people at the home couldn't communicate. They said they stayed in their room all day.

We looked in detail at five care records for people living in the home and we had concerns about all of them. Care records were poor and out of date and most people's care had not been reviewed for a long time. We saw that most care records did not reflect people's current needs.

For example we saw one care plan that said the person could walk unaided. We observed the person and saw that they could not walk without a frame and support from staff. We noted that no care files had moving and handling assessments in them which meant that staff were supporting people to mobilise without any guidance. This placed people at potential risk of harm.

Two people had visual and hearing impairments that affected their ability to communicate. We saw that there was a sight, hearing and communication assessment in one person's file but it was blank. The assessment itself was meaningless and did not ask the right questions in relation to the person's visual and hearing impairments to enable the provider to plan appropriate and safe care.

One person's daily notes indicated that they had continence needs but their care plan stated they had no continence issues and could independently go to the toilet. There was no evidence in the person's file that a referral to the continence team had been made in relation to this person's needs. We saw from the person's daily notes that the person's family were bringing in continence products for the person to use. We asked a staff member if the person had been referred to the NHS continence team for an assessment of their continence needs. They were unsure. We spoke to the district nurse team in relation to this person's care who said they would put in an urgent order for the person's continence needs.

We found that overall dementia care planning and the person centred planning for people's emotional needs and risks was non-existent. Where people had emotional needs or behaviours that challenged, there was no evidence they had been risk assessed and appropriate support planned. There were no behavioural charts in place to monitor people's unwanted behaviours and care plans held no information about the frequency, intensity or triggers to these behaviours in order to assist with their management. There was also no guidance to staff on how best to support the person when these behaviours were displayed.

For example one person was described as having challenging behaviour and episodes of distress. There was no evidence that the cause of the person's distress had been explored and no guidance to staff on how to alleviate the person's distress when they became upset. We also saw that there was no evidence in the person's care file to indicate staff had learnt from unwanted incidents or revisited their approach to the management of these incidents in order to support the person emotional health and wellbeing. The person's daily notes indicated they continued to be unsettled and prone to emotional upset.

We asked staff about baths and how often that people could have them. Staff told us that people in the home did not have baths because of a lack of safety equipment,

inaccessible bathrooms and staff time to support them. We asked about how people were supported with their personal care and we were told by staff that they washed people with a bowl of water in their bedrooms.

These examples are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider was failing to provide safe and appropriate for care for people who lived at the home.

We checked the provider's bathing equipment and saw that one bath hoist was out of order and the other had clearly not been used for some time. We asked to see the provider's LOLER (Lifting Operations and Lifting Equipment Regulations 1998) which certifies that the bath hoists are safe to use and of an appropriate standard. The provider gave us copies of the last LOLER test undertaken by a professional body. We saw that the hoists had not been tested since February 2014. We saw on the certificates provided that the professional body undertaking the test had specified that the next test was due in August 2014. There was no evidence that this or any further tests had been undertaken. By law LOLER tests are required to be undertaken by a competent person every six months. This meant the provider failed to ensure the equipment in use was safe for the purpose intended and free from detect.

We checked the provider's shower and saw that shower door did not properly fit the shower doorway and that access to the shower by staff in order to assist people with bathing was difficult. We tested the shower and found that there was no hot water.

One staff member told us that a person who had mobility problems had expressed a wish to sit in a particular place but that the staff team where unable to facilitate this as the home did not have the moving and handling equipment in place to enable this to happen. They said the person's family had said they would buy the equipment for the person but that staff had had to decline this offer as there were not enough staff on duty to undertake this task at any one time. They said "It's abuse as we cannot meet her needs".

The staff member said that the person required regular repositioning. They said they had asked the provider for a slide sheet so that they could reposition the person safely. They said the provider provided a slide sheet but none of the staff had been trained in how to use it safely. Despite this staff were continuing to use the slide sheet to reposition the person every two hours.

After our inspection we made safeguarding referrals to the Local Authority in relation to three people who lived at the home and the care they received.

These examples were also breaches of Regulation 16 and Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12, 15, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to ensure adequate and appropriate equipment was available to meet people needs and failed to maintain appropriate records of people's care needs and risks.

One person we spoke with told us they had made a complaint that been dealt with by the provider. We reviewed the provider's records and also saw that where formal complaints were made, these had been responded appropriately by the provider.

The breaches identified are being followed up and we will report on any action when it is complete.

Inadequate

Is the service well-led?

Our findings

On the first day of our inspection the provider spoke with us on the telephone and informed us that a new manager had been recruited and was commencing work the following week. We asked the staff and they told us that the provider had told them that a new manager had not been recruited.

During the second day of our inspection we observed friction between staff and the provider. This demonstrated to us that there was not an open and transparent culture between the staff and the provider. The culture of the home seemed very poor and the provider blamed staff for the concerns that we raised. We found that the provider failed to show any accountability or responsibility for any of the issues we raised at the home.

One person we spoke with told us the management at the home was constantly changing. They said that in the last few years there had been five different managers. A healthcare professional we spoke also said "The biggest issue is that the management has changed a lot. This has hindered some working relationships".

We checked what systems the provider had in place to manage the health, welfare and safety risks posed to people who lived at the home. We found a lack of adequate systems in place. Those systems that were in place were poor and their operation by the provider was not well managed. For example, we saw that no meaningful audits had been completed. One medication audit had been completed but failed to identify any of the issues we found with the administration, storage and management of medication.

Only one care plan audit had been completed following our previous inspection where enforcement action had been taken in relation to the assessment, planning and delivery of care. We found that only one accident and incident audit had been undertaken. It provided little useful information however to enable the provider to monitor trends in the types, location and/or times of accident/incidents in order to learn from how accident and incident occurred so that they could be prevented. This meant the audit was meaningless and ineffective.

There were poor or no audit procedures in place for infection control, building safety, staff support and supervision. Regular audits would have identified the issues we identified during our inspection so corrective action could have been taken.

We raised concerns with the provider over the lack of effective quality management systems in place at the home. We found that the provider failed to show any accountability or responsibility for the lack of effective systems in place. This showed us the home was not well led or well managed in the delivery of care by the provider.

We asked about staff feedback. We were told that staff questionnaires had been given and the feedback collated. Staff told us that they had no confidence that issues raised would be tackled as the provider did not take on board their comments. The provider told us that they had "bent over backwards" to accommodate the staff and could not do it anymore.

We saw no evidence that people who lived at the home and/or their relatives had been asked for their feedback on the care provided by the home. This meant the provider did not have a system in place to enable people's views to be sought so that they could come to an informed view of the quality of the service provided so that improvements could be made and any suggestions acted upon.

These examples are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010. This was because the provider did not have an effective system of operations to assess and monitor the quality of the service or enable people to feedback their views so that improvements could be made.

The breaches identified are being followed up and we will report on any action when it is complete.