T D Bailey Investments Limited

The Dulwich Care Centre

Inspection report

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Ratings

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

Overall summary

The Dulwich Care Centre provides accommodation for nursing and personal care for up to 92 people. At the time of our inspection 75 people were using the service. The service is split across four floors. The lower ground floor provides residential care, the ground floor provides general nursing care, the first floor provides nursing care for people with dementia, and the second floor provides residential care for people with dementia.

At our previous scheduled inspection on 6 June 2013 we found the service was not meeting the regulations we inspected relating to care and welfare of people using the service, meeting people's nutritional needs, supporting workers and care records. We undertook four follow up inspections to review the quality of care provided to people who used the service. At our last inspection on 6 March 2014 we found the service to be meeting the regulations inspected.

The service had a registered manager in post as required by their registration. 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

Summary of findings

about how the service is run. The registered manager in post at the time of our inspection had been registered with the Care Quality Commission since they started at the service in April 2013.

Accurate records were not kept about people's care and support needs. People did not always receive the support they required in line with their individual needs and to maintain their welfare and safety. Information was missing about risks to people's safety and how these were to be managed. Some staff had limited knowledge about people's needs and felt they did not have the skills and knowledge required to support people with all aspects of their care, including meeting their mental health needs and provision of activities.

Staff did not always receive the training and support they required to ensure they had the skills to meet people's needs. There were insufficient staff to provide a responsive service.

People were not always treated with respect, and their privacy and dignity was not always maintained. There was a lack of activities provided at the service, and little interaction or engagement with people who used the service.

Concerns and complaints raised by relatives of people using the service were not always listened to or responded to in a timely manner. The service did not use information from complaints or incidents to improve the quality of the service.

People and their relatives were involved in decisions about their care, and 'best interests' meetings were held in line with the Mental Capacity Act 2005 for people who were unable to make decisions about their care. People were able to see healthcare professionals, including the GP, as required.

Medicines were securely stored and appropriately administered. Checks were undertaken by the provider and the registered manager on the quality of service provision.

We found breaches of the regulations relating to the care and welfare of people using the service, maintaining the privacy and dignity of people using the service and treating people with respect. There were also breaches of the regulations in relation to staffing levels, support and training provided to staff, the systems for monitoring the quality of service provision, complaints, care records and notifications. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe. Risks to people's safety and welfare were not consistently identified and managed. Care records were not kept up to date particularly in regards to prevention of pressure sores and dehydration.

There were not sufficient staff to meet people's needs. People were unable to get the assistance they required when they needed it. Call bells were not always answered on time and people had to wait for assistance at mealtimes.

Medicines were stored securely and administered safely.

Is the service effective?

Requires Improvement

Some aspects of this service were not effective. Some staff did not have the knowledge and skills to meet people's needs, particularly in regards to people's mental health and dementia diagnosis. Staff had limited knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. There were inconsistencies in the support staff received through formal supervision sessions.

People were given a choice of meals and were able to request alternatives if they wished.

People were able to see health care professionals as required to ensure their health needs were met and they had access to specialist advice and support as needed.

Is the service caring?

Requires Improvement

Some aspects of this service were not caring. People's privacy and dignity were not maintained at all times. Staff were often task focussed which impacted on the quality of interactions.

People and their relatives were involved in decisions about their care, and 'best interests' meetings were arranged as necessary if a person lacked the capacity to make decisions about their care.

Is the service responsive?

Inadequate

This service was not responsive. People did not always receive the care and support they required in regards to meeting people's personal care, emotional and psychological needs. People's care records did not contain sufficient information about their care and support needs, in order for staff to be able to provide a service that met people's individual needs.

Summary of findings

There was a lack of activities offered at the service, and we observed people being left in the communal lounges with nothing to engage or stimulate them.

Relatives were not adequately supported to make a complaint, and complaints were not consistently responded to in a timely manner. Lessons were not learnt from the complaints received to improve the quality of care provided.

Is the service well-led?

Requires Improvement

Some aspects of this service were not well-led. The service did not have adequate systems in place to record incidents and learn from them to reduce the risk of the incident recurring.

The service did not adhere to the conditions of their registration with the Care Quality Commission and we did not receive all the required statutory notifications.

We received mixed messages from staff about the support provided by the manager, and some staff felt unable to have open and transparent discussions about service provision.

There were systems in place to monitor the quality of service provision and regular checks were undertaken by the provider on the quality of care provided.

The Dulwich Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 November 2014 and was unannounced.

The inspection team included two inspectors, a specialist professional advisor, an expert by experience and a member of the Care Quality Commission Board. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist professional advisor had specialist knowledge of providing care to people with dementia.

Before the inspection, the provider completed 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. We also reviewed the information we held about the service.

During the inspection visit we spoke with 14 people who use the service, two people's relatives, 14 staff, the registered manager, and two visiting professionals including a community nurse and a social worker. We reviewed 12 people's care records. We read four staff recruitment records and training records for the staff team. We looked at records relating to the management of the service including incident records, complaints and quality checks.

We undertook general observations of people's care and support in the communal areas on each floor. We used the Short Observational Framework for Inspection (SOFI) tool when people on the first floor had their lunch. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection we spoke with two relatives/ representatives of people who use the service, a representative from one local authority who funds placements at the service, a representative from the local safeguarding team, members of the community mental health team and the discharge co-ordinator from a local hospital.

Inadequate

Is the service safe?

Our findings

Risks to people's safety and welfare were not consistently identified and managed. Some people's care records clearly outlined the potential risks to their safety and the plans that had been put in place to support them to keep safe. In other instances risks to a person had been identified but no effective action had been taken to reduce the risk of harm. For example, one person was assessed as being at risk of self-neglect and a risk to the safety of others. There were no plans in place to manage the risks identified. It was documented that this person displayed behaviour that challenged the service. However, there was no detailed information about any triggers to the behaviour or how to reduce the risks of it occurring. Nor were there any guidelines on how to support the person or others if they became distressed. Representatives from the community mental health team told us that information had been identified upon people's admission to the service about the challenging behaviour people displayed however this information was not always passed on to the staff team and staff were often unaware of the verbal or physical aggression that people displayed.

People using the service were regularly weighed. One person's records showed they had consistently lost weight over the year but there was no evidence of any review of the risks to the person's health due to the weight loss and no plans were put in place to address this risk.

Environmental risks were not consistently identified and managed to maintain the safety of people using the service. We observed on the second floor that people were supported to have a shave. This was done in the communal lounge and the shaving equipment including disposable razors were kept in an unlocked drawer in the lounge. On the first floor there was one corridor that had renovation and building work taking place. The door between this corridor and the main communal area of the floor was not locked. On the corridor were a number of unlocked rooms containing building equipment and materials providing potential hazards to people using the service. We observed on the day two people accessing this area. They were quickly supported by staff to come back to the main area but there was a risk that people could access the area unnoticed.

We could not be assured care was planned and delivered to ensure people's welfare and safety. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's safety and welfare was at risk because the service had not kept accurate records. The care records for a person using a wheelchair did not include the appropriate information about their mobility needs. There were no guidelines for staff about how to support them to safely move around the service and transfer in and out of their wheelchair. The person had a care plan to maintain their skin integrity which stated they were at risk of developing pressure ulcers, but there was no information about how to prevent pressure ulcers developing.

Another person had restricted mobility. Their records stated staff should support them to be repositioned to minimise the risk of them developing pressure ulcers. However, no record was made of when the person was repositioned and therefore we could not evidence that the person received the preventative measures they required to maintain their safety. Staff told us this person was also required to have a fluid chart to monitor their fluid intake as they were at risk of dehydration. The person's records did not include information on how much fluid they should be receiving each day to meet their needs. Staff told us the fluid chart was in place to ensure the person had some fluid every hour, however, we noted that between 19:00 on 12 November 2014 and 07:00 on 13 November 2014 only two 10ml recordings had been made. This indicated that the person did not receive the fluids they required in the evening and through the night.

Another person had been identified on their assessment record as at high risk of becoming malnourished. There was no information in their eating and drinking care plan that referred to this risk or how they were to be supported to eat and drink sufficient amounts. A note that been made on their records that the person's fluid intake should be monitored on a fluid chart as they were at risk of dehydration. We could not locate the fluid chart for this person. We asked a staff member about this. They told us they had accidentally recorded the information on this person's records and it referred to another person using the service. However, they also said that they thought this person required a food and fluid chart to monitor their eating and drinking because of the risks posed and they were going to implement this later into their shift.

Inadequate

Is the service safe?

A person had recently had a fall and they were admitted to hospital for further assistance with their medical needs. They had been discharged back to the service. Their care records had not been updated since their return to the service and did not evidence that the risk of them having another fall had been assessed and there was no information recorded on their current support needs in regards to their mobility.

We could not be assured that people were protected from the risk of unsafe or inappropriate care as accurate records were not kept. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us they adjusted staffing levels at the service according to the dependency and complexity of people's needs. They said they were aware that people on the first floor required additional support, due to it having many new admissions and new staff members, whilst people settled into the service and staff got to know their needs. They told us they planned to deploy one additional care assistant to the floor the week after our inspection for as long as people's needs required it. However, we were informed that this did not occur and the staffing level on the first floor was not increased.

We spoke to two people on the lower ground floor who told us they both had call bells within reach and told us staff came when they pressed the bell. On the day of our inspection, one of them pressed their call bell because they needed assistance. However, we observed that no staff responded until it was bought to their attention by a member of the inspection team. A relative of a person using the service told us that often call bells went unanswered. They told us on one occasion the person's call bell was left ringing and staff were unable to attend to their needs for three hours because there were not enough staff on duty.

We observed that at times people were left on their own in the communal lounges, particularly on the lower ground and second floor. One person told us they would like a cup of tea but there were no staff around for her to ask. It took 15 minutes before a staff member came into the lounge. During this time we observed a person wandering around the lounge and they grabbed hold of another person's handles on their wheelchair. The person in the wheelchair was observed as being distressed. There were no staff available in the lounge to support either person.

During mealtimes people did not always get the support they required. We observed on the lower ground floor that one person was served their food first. They pushed this away and did not start to eat it. It was only after staff took the time to sit with this person and support them that they ate their meal. However, the person was left waiting 30 minutes before they got the support they required. On the second floor two people required support with their meals. Both people got given their meals. However, there was only one staff member available to support people at the time of the meals being given. This meant one person had to wait ten minutes before another staff member was available to support them with their meal.

We observed on the first floor that staff tried to engage people in activities but with little success due to there not being enough staff to provide people with the one to one support they required to undertake an activity.

Staff told us they felt there were not enough staff to provide good quality care to people who used the service. They said they did not feel they always had enough time to provide care and support to people and spend one to one time with people. We were told by staff that having one care assistant and one nurse per floor on the night shift made it difficult to meet people's needs promptly. For example, if a person required support from two people with moving or personal care during the night there were no other staff available to answer call bells or assist other people with their care needs.

We could not be assured there were sufficient staff to meet people's needs, maintain their safety and provide a responsive service. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We reviewed the recruitment records for four staff. They showed that safe recruitment processes were followed. Staff had completed an application form and attended a formal interview. References had been obtained from previous employers to check staff were of good character and had good employment histories. Checks were also undertaken of an applicant's identification and their eligibility to work in the UK. Criminal records checks were undertaken to ensure staff were safe to work with vulnerable people.

Staff we spoke with were knowledgeable about how to recognise safeguarding concerns and report concerns

Inadequate

Is the service safe?

about a person's safety to the registered manager. Records confirmed the registered manager had liaised with the local authority's safeguarding team as required on any concerns raised.

Staff were aware of first aid arrangements and what to do in an emergency so people received the care and support they required. However, on the day of our inspection we heard that one person's relative was concerned about a person's health and felt staff were not forthcoming and cooperative in calling an ambulance to obtain further medical assistance.

Staff we spoke with had appropriate knowledge of safe medicines practice. Medicines were securely stored. We reviewed 19 medicine administration records (MAR) and saw they were completed correctly. There were clear processes in place for the storage and administration of controlled drugs. The staff we spoke with understood and adhered to these processes. We observed medicines being administered on the second floor. Staff explained to people what medicines they were given and how their medicines were to be taken. For example, one person received a medicine that they were required to chew rather than try to swallow it whole.

Some people required the application of topical creams. The staff we spoke with confirmed they were aware of what cream was required to be applied, where and how often. The manager had undertaken audits to review this practice and confirmed creams were applied as prescribed to ensure people's needs were met.

Requires Improvement

Is the service effective?

Our findings

Staff told us they had received an induction. However, we spoke with one nurse in charge of a floor who was newly employed and they were still getting to know the people they were supporting. They were unable to explain people's care needs, their preferences or whether the person had capacity or not to make decisions. We found the induction did not provide staff with sufficient time to get to know the people they were supporting.

A programme of training was available to staff to update their skills and knowledge so they were able to support people using the service. Records confirmed that the majority of staff had completed mandatory training including manual handling, fire safety, health and safety, medicine management and infection control. Staff were expected to complete their mandatory training annually. However, 13 out of 38 care staff (including nurses and care assistants) had not received training in safeguarding adults. One staff member told us they had not received safeguarding adults training in the last two years. The service was due to deliver a five month training programme to 12 staff on dementia care but at the time of our inspection only four of the care staff had completed training in supporting people with dementia.

We saw that other specific training in relation to meeting people's complex needs had not been completed by many staff. For example, only six staff had completed training on the prevention of pressure ulcers, and only one staff member had completed training on catheter care. There was nothing recorded on the provider's training matrix that staff had received training on the Mental Capacity Act (MCA) 2005 or the Deprivation of Liberty Safeguards (DoLS). The registered manager told us MCA and DoLS training was scheduled to be delivered in 2015. A staff member told us they felt they did not have the skills and knowledge to support people's mental health and that they required additional training in order to meet people's psychological needs. Representatives from the community mental health team felt staff required additional training on DoLS, supporting people with mental health needs and dementia, and managing challenging or aggressive behaviour. Another staff member told us they felt they required additional training now care staff were expected to deliver the activities at the service, in order to have the skills and knowledge to provide meaningful activities to people who used the service.

We received mixed messages about the formal support provided to staff by the management team through supervision sessions. One staff member told us they had not received supervision in the last three years. They told us they had received an appraisal in the last year where they discussed their training needs but they told us this was not followed up and no action was taken to address the concerns raised. Whereas, another staff member told us they had received three supervision sessions in the last eight months. They found the sessions were a good opportunity to feedback and reflect on their practice. We asked the registered manager to send us information to confirm when staff had received supervision. However, the information we were provided with did not reflect the whole staff team and we could not be assured that all staff at the service received the supervision they required. Staff that had been at the service for longer than a year had received an appraisal reviewing their performance.

We could not be assured that people always received support from staff who had the skills and knowledge to effectively meet their needs. Staff were not consistently supported to update their skills and knowledge and they were not always adequately supported through regular supervision. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with had some knowledge of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and what determined whether a person was deprived of their liberty. The service had made a DoLS application which had been authorised. The discharge co-ordinator from the local hospital confirmed 'best interests' meetings were held for people who were unable to consent to having their care at the service and management of their finances.

People gave us mixed feedback about the quality of the food at the service. One person told us, "The food is good. I like it very much. We have a choice." Whereas, another person said, "The food is useless. The portions are small and it's not good quality." This person told us they were

Requires Improvement

Is the service effective?

unhappy with not having a main meal as their evening meal and said they often went to bed hungry. Some people told us they often bought their own food in and kept it in the fridge in their rooms.

There was a choice of meals available at lunchtime and we observed that one person had requested an alternative meal that was not on the menu and this was provided for them. However, one person told us they had requested a particular breakfast upon referral to the service but they had not been provided with this meal since being at the service. We informed the registered manager of this and they could not provide us with a reason why the person had not received their choice of breakfast and they would follow this up with the catering team.

During our SOFI observation on the first floor at lunchtime we observed that it took a long time for people to get their meals. Staff were focused on getting people their meals, without providing quality interaction or spending the time with people to support them to eat their meals. We observed a 15 minute wait between people asking for dessert and it being bought up to the floor. This led to three people leaving the dining room before dessert was served.

At lunchtime on the second floor we observed that a soft diet was available for people who required it. People on this floor received appropriate support from staff when required. We observed one person receiving assistance from staff. The staff member explained to the person what was on the plate, and checked with the person throughout the meal whether they liked it and whether the pace of the support provided was appropriate. The meal was not rushed and people were offered drinks throughout.

People were happy with their access to medical care. One person said, “You can see the doctor when you want to, you just put your name on the list” and another person told us they could see the doctor “anytime”. A GP visited the service and people were referred to the GP as required to ensure they had their primary medical needs met. One person informed us they had pain in their shoulder. We informed the staff on duty of this and they confirmed they were aware of this, the GP had reviewed them and a referral had been made to the hospital to obtain further medical assistance. People using the service for respite continued to be registered with their own GP practice and were supported to access an out of hours GP service if they required medical attention whilst using the service.

People were referred to health professionals as required. A community nurse was visiting on the day of our inspection. They provided clinical care to people on the residential floors, giving people insulin, changing dressings and reviewing catheter care. They told us they had no concerns about the care provided to people using the service. Care records showed the service was in liaison with the dietetics service about how to support people with specific dietary requirements, and worked with the tissue viability nurse to ensure people with pressure ulcers received the care they required. At the time of our inspection, the registered manager told us they had gone 200 days without a pressure ulcer being acquired at the service.

A domiciliary dental service visited the home to provide people with dental care. However, we spoke with one person and observed their dentures were ill-fitting and did not stay in place as they spoke. They told us, when asked about their dentures, that they were a bit loose. No referral to a dentist or assistance was provided to get this person appropriate fitting dentures. The registered manager told us they would ensure the person received the support they required with their dentures.

Requires Improvement

Is the service caring?

Our findings

Most people we spoke with were positive about how they were treated by staff at the service. One person told us, "They [the staff] couldn't do more for me." Another person said, "The staff are all very good. Everyone's very kind to me here." One person's relative described the staff as "wonderful" and in regards to one particular staff member, "they looked after [the person] really well." One person told us, "The night staff are good too." However, another person said, "Staff have no manners, the night staff in particular". This person told us that staff had refused on occasion to empty their catheter bag. Another person's representative told us the manager had "no time for people… the manager talks down to people."

We observed that at times people were not treated with compassion and their privacy and dignity was not maintained. During our SOFI at lunchtime we observed that some people did not get the support they required. One person required assistance and encouragement to eat. They kept raising their knife with food on it asking staff, "is this alright?" Staff often did not respond to this person and so they had to get up and approach staff to get an answer. We observed that staff often put plates of food in front of people without the staff member looking at them and much verbal interaction took place without eye contact being made.

During our inspection we observed that one person was supported to have their weight checked, however the staff hurried this person and did not notice that their slipper had fallen off. Another person, on a different floor, was in the lounge area with only one slipper on. A member of the inspection team found their other slipper under the dining table and returned it to them. We observed one person had a hole in their sock with their toe sticking out. Another person was observed to have stains on their clothes and were trying to brush them off. Their relative told us this was distressing to the person as they always liked to be smart and well-dressed. Staff only assisted this person to change their clothes after it was bought to their attention by a member of our inspection team. When we were in a communal lounge we observed that a person wished to empty their catheter bag. There were no staff in the lounge at the time. Another person using the service had also noticed that the person was going to empty it themselves and asked a member of staff to assist the person. However, the person was not supported to do this in the privacy of their own room or the bathroom and it was emptied into a bottle in the lounge in front of other people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed that one person's care plan had detailed instruction to staff to ensure a person's privacy including ensuring the person's door was closed whilst they were assisted with their personal care and knocking before entering people's rooms. We observed that staff put these guidelines into practice on the day of our inspection when supporting people in their rooms.

There was varying levels of detail in people's care records about their preferences, interests and hobbies. Two of the care records we viewed included detailed information about people's preferences and interests. This included people's preferred night time routine, their preferred drinks, meals they enjoyed, previous occupation and activities that they liked to be involved in Other people's care records we viewed did not include this information. We informed the registered manager during our feedback session on the inspection visit that we found some care records that did not include sufficient information about the person. The week following the inspection the manager sent us copies of newly developed care plans for these individuals outlining their likes, interests and their daily routines.

Some people's records included information about how they communicated and any restrictions to their communication due to memory lapses and how the person was to be supported to ensure their views and opinions were listened to.

Representatives from the local authority told us they received feedback from relatives that they were involved in discussions about the care people received at the service, and discussed information relating to people's routines and preferences. However, they said they had found that often this information was not documented in care records and therefore not all staff were aware of this information.

People were encouraged to make decisions on a day to day basis and, when able to, participate in decisions about their care. If people were unable to make decisions about their care, health and social care professionals and

Requires Improvement

Is the service caring?

relatives were involved in the decision making process. We saw and heard that relatives were kept informed of any changes in people's care needs and the support they required.

An independent mental capacity advocate (IMCA) was available through arrangements with the funding authority to support people to make decisions about their care. The registered manager told us one person was currently receiving support from the IMCA.

Information about people using the service and their care needs was not always kept confidential. We observed that whilst the majority of people's care records were managed and stored electronically there was still some paper records kept. The paper records were not always stored securely. For example, we saw that at the staff station on the second floor one person's hospital discharge notes were placed on the desk.

Inadequate

Is the service responsive?

Our findings

We were informed by one person's representative that people's care needs were not always met. They told us they frequently went to visit the person using the service and on six occasions during November they found the person's continence needs had not been met and they required support with their personal care. They said staff supported the person once it had been bought to their attention but they raised concerns that staff were not proactive in meeting this person's needs. Another person's relative also told us they found their relative had not had their personal care needs met and they were lying in urine and faeces.

We observed that people's emotional and psychological needs were not consistently met. One person was in for respite care and their records stated they were "low" in mood. There was no information or plans in place as to what this meant for the person or how staff were to support this person with their mood. Two people's care records we viewed had a diagnosis of depression on their records but there were no care plans about how to support these people with this diagnosis and the staff did not mention it when identifying the person's care and support needs. Representatives from the community mental health team told us they found some staff were not aware of people's mental health diagnoses or backgrounds. They also told us that information had been shared with the service about a person's mental health needs but this was not passed onto other staff members meaning appropriate care and support could not be delivered.

We could not be assured that consistently received care that met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed that people's care records were not always sufficiently detailed to ensure staff were aware of people's needs and how people were to be supported. For example, one person was diagnosed with dementia and Parkinson's. However, their care records did not include any information about how the person was to be supported with these conditions. This person also had arthritis but there was no information about what impact their arthritis had on their ability to be independent with their personal care or what support they required from staff. Another person's care records stated they had "physical health problems." There was no information about what physical health needs this person had or how they were to be supported.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection we observed that staff on the first floor interacted briefly with people and spent short amounts of time speaking with people. However, overall we observed the majority of people sitting in the communal areas not engaging with others or activities. On three of the floors both the television and the radio were on in the communal lounge, which meant people were not able to listen neither to one nor the other. On the other floor we observed that people were in the lounge but there were no activities taking place, the television was not on and there was no music. There was nothing occurring to stimulate or engage people. Feedback from the latest satisfaction survey completed by relatives stated they were unsatisfied with the social activities on offer at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff told us they wished to make improvements at the service and increase the number of activities on offer.

Two people we spoke with preferred to spend time in their room and they told us they were happy with their own activities. Another person told us they regularly went to church and went to events organised by their church group.

The service's complaints process was displayed for people to see and the process was for all complaints to be escalated to the registered manager so they could investigate appropriately. Staff told us concerns were often discussed and dealt with prior to them becoming formal complaints. The complaints records showed that four complaints had been made in the last year. One person contacted the Care Quality Commission because they felt their complaint was not being responded to in a timely manner. At the time of our inspection their concerns were being investigated by the local authority as a safeguarding concern. The other three complaints had been investigated and responded to. The complaints records we observed acknowledged and apologised where the service or staff were at fault. One complaint we reviewed mentioned that a person's call bell was left out of reach. In seven rooms on one floor we observed that call bells were either missing or placed behind beds or chairs making them inaccessible to

Inadequate

Is the service responsive?

people. Therefore we could not be assured that the service consistently learnt from the complaints made to improve the service provided. We received phone calls from two relatives/representatives of people using the service after our inspection who told us they had made a number of complaints to the service but that they did not hear back about their complaint and did not see any action taken to address their concerns. They told us, "It's all brushed under the carpet" and "we never hear back" in regards to the concerns raised. We could not be assured that there were sufficiently robust processes in place to support people to make a complaint, investigate and respond to a complaint. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A relatives' meeting was held quarterly where relatives were invited to come and discuss the service. This gave people the opportunity to raise any concerns they had and to inform the registered manager and staff where they thought improvements were required. We heard that some relatives had reported that the outdoor furniture on the second floor balcony was worn and needed replacing. The registered manager assured us that new furniture would be purchased for next spring so people were able to sit outside when the weather allowed.

The registered manager told us they received ongoing feedback from people and their relatives as they often came to see her in her office and when she was on the floors. The registered manager told us they received positive feedback about the quality of the service provided from relatives.

A survey was sent to people and their representatives to obtain their views of the service. We saw the findings from the latest survey in June 2014. The findings showed that the majority of people were satisfied with the service provided. There were areas where some people thought improvements could be made. These areas were: the variety of food on offer, additional snacks being provided, and the social activities on offer. The provider did not have an action plan to respond to these concerns.

Requires Improvement

Is the service well-led?

Our findings

One person told us, "I don't know who the manager is. I wouldn't know her if I saw her." Two people told us they thought staff should wear uniforms and that "they don't wear labels. I don't always know who they are." One person told us, "Since I came here the manager has not come to see me."

The service did not complete the statutory notifications as required in line with their registration with the Care Quality Commission. One person using the service was subject to the Deprivation of Liberty Safeguards, however we were not notified of this. There was some confusion over notification of allegations of abuse and we subsequently were not notified of two allegations of abuse. We informed the registered manager of this and they sent in a notification two working days after our inspection of one of the allegations of abuse but not the other. We identified during our inspection that one person had had a fall which resulted in a fractured hip however we were not notified of this serious injury. During our inspection a person was admitted to hospital with a serious condition however we were not formally notified of this. This meant we were not able to follow up with any regulatory action required to ensure the safety and welfare of these people. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

All incidents and accidents were recorded. However, we saw that many of the incidents were recorded in an accident book which did not allow for sufficient detail to be captured about the incident, what action was taken into response to the incident or how it fed into the care and support provided to people who used the service. For example, one incident recorded was due to a person leaving from the service. There was no information about how the person was supported, whether there was a further risk that the person was going to leave the service, the risks to the person if they left or whether the person required use of the Deprivation of Liberty Safeguards for their own safety. We saw another incident was recorded where a person had been injured transferring from their wheelchair. There was no information as to how the injury occurred, whether it was an accident or how it could be prevented in the future. A third incident was due to a physical altercation between two people using the service. There was no record that this had been referred as a safeguarding concern or any protection plans in place to ensure the safety and welfare of both people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager had been in post since April 2013. Under their management there was a leadership structure, including a clinical lead and a residential and facilities manager. The registered manager told us they were working on making the leadership team's roles and responsibilities clearer so staff knew who to approach and the reporting process if they had concerns.

The service had experienced a large turnover of staff with 26 staff leaving the service and 49 staff joining the team within the last year. At the time of our inspection the staff were still getting to know each other, and some staff told us they enjoyed their work because of the team work and open communication within the team. However, we also heard from one staff member, "The manager treats [us] as if we don't count. New staff are the priority." The manager was working with the teams on each floor to ensure staff knew their roles and responsibilities, and encouraging staff to take ownership of some of the duties and developments at the service.

At the time of our inspection the registered manager set the staff rota. Staff told us the rotas were often set only two days in advance and this meant they were not able to make any plans in their private life as they were unsure what shifts they were working until the last minute. Staff told us there was also confusion over annual leave arrangements, and they were not always informed if their annual leave had not been approved.

Floor meetings were held where staff were able to discuss the needs of people using the service. The registered manager attended these meetings as necessary to either disseminate information to the staff team and to hear any concerns being raised by staff so that appropriate action could be taken. The service also held heads of department meetings where representatives from each floor and each discipline at the service came together to discuss the needs of people using the service and to share good practice across the home.

The registered manager told us, and staff confirmed, that staff were encouraged to take a lead on activities and developments at the service. We heard that one care assistant was musical and a piano had been purchased so

Requires Improvement

Is the service well-led?

they could lead music sessions and sing-alongs in the communal area on the ground floor. Another staff member told us they had suggested the opportunity of having a kitchen where they could do baking with people using the service. A small kitchen was being built as part of the renovations on the first floor to accommodate this.

We received mixed messages from staff about the support they received from the manager. Some staff told us they did not feel supported by the manager and did not feel comfortable talking to her if they had concerns. One staff member told us, "The manager is not approachable, doesn't listen." Another staff member told us they would not go to the manager if they had concerns, they would go straight to the provider. Whereas other staff told us they liked the manager, felt well supported and were encouraged to ask any questions they had. They felt the manager was approachable, they felt comfortable raising any concerns they had and felt they had the opportunity to bring about change and improve the service delivered.

There were processes to check the quality of the service provided. Checks were undertaken to review medicine management processes, health and safety, and catering arrangements. We viewed the findings from the latest audits and saw that when action was required an action plan was produced. We saw that either the actions had been completed or were in the process of being addressed at the time of our inspection. The registered manager undertook unannounced visits during the night to check on the quality of service provision out of hours. The findings from these checks were that people's wishes and choices were respected. One person called for assistance from staff and wished to get up early and the staff supported them to do so. The registered manager collected data monthly to review people's dependency levels and any changes in their care needs. The provider also undertook spot checks to review the quality of the service. Checks were undertaken on people's care records. However, the records we saw checked that care plans and risk assessments were completed, they did not comment on the quality of the records.

The service was involved in local initiatives. They were working with two local authorities reviewing discharge arrangements from hospital to a care home to improve communication and information sharing. The service was also working with one local authority looking at reducing inappropriate admissions to A&E for people with dementia.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure planning and delivery of care ensured the welfare and safety of the service user. Regulation 9 (1) (b) (ii). The registered person did not take proper steps to ensure planning and delivery of care met the service user's individual needs. Regulation 9 (1) (b) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not have effective systems to, where necessary, make changes to the treatment or care provided relating to the analysis of incidents that resulted in, or had the potential to result in, harm to the service user. Regulation 10 (2) (c) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not make suitable arrangements to ensure service users were treated with consideration and respect. Regulation 17 (1) (a) (2) (a). The registered person did not make suitable arrangements to provide appropriate opportunities, encouragement and support to services users in relation to promoting their autonomy, independence and community involvement. Regulation 17 (2) (g).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have an effective system in place for ensuring any complaint made was fully investigated or resolved to the satisfaction of the complainant. Regulation 19 (1) (2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not take appropriate steps to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff for the person of carrying on the regulated activity. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure staff were adequately supported to deliver care to service users safely and to an appropriate standard by receiving appropriate training and supervision. Regulation 23 (1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Commission without delay of incidents that led to injury which resulted in changes to the structure of a service user's body; allegations of abuse in relation in to a service user, a request to a supervisory body for a standard authorisation. Regulation 18 (1) (2) (a) (ii) (c) (e).

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	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from the lack of proper information about them by means of an accurate record in respect of each service user which includes appropriate information and documents in relation to the care and treatment provided.

The enforcement action we took:
A warning notice was issued