

Ringdane Limited

Dane House Care Home

Inspection report

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Date of inspection visit: 13 & 14 November 2014
Date of publication: 27/01/2015

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

We inspected Dane House on the 13 and 14 November 2014. Dane House Care Home is registered to provide care to people with nursing needs, many of whom were living with dementia. The home can provide care and support for up to 22 people. There were 21 people living at the home during our inspections.

Dane House Care Home belongs to the large corporate organisation called Four Seasons. Four Seasons provide nursing care all over England and have several nursing home within the local area.

The accommodation is over two floors with a communal lounge and conservatory. Although care and support is provided for people living with dementia, the home is not specialised in dementia care.

A manager was in post, but they were not the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The home has been without a registered manager for nearly a year.

At the last inspection in August 2014, we asked the provider to make improvements in respecting and involving people; care and welfare, staffing, supporting

Summary of findings

workers and quality assurance. An action plan was received from the provider which stated they would meet the legal requirements by 11 November 2014. Improvements had not been made.

People spoke positively of the home and commented they felt safe at the home. Our own observations and the records we looked at did not always reflect the positive comments some people had made.

People's safety was being compromised in a number of areas. Care plans did not reflect people's assessed level of care needs. Staffing levels were stretched and staff were under pressure to deliver care in a timely fashion.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the MCA Code of Practice.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Information was not readily available on people's life history and there was no evidence that people were involved in their care plan.

Everyone we spoke with was happy with the food provided in the home. However, we found lunchtime to be chaotic with people not receiving their lunch until

2pm. A communal dining experience was not made available to people and they ate their lunch either in their rooms or sitting in the lounge watching television. People were not always supported to eat and drink enough to meet their needs.

People's medicines were stored safely and in line with legal regulations. People received their medication on time and from a registered nurse. However, the home did not undertake pain assessments for people living with dementia or communication needs. Therefore, there were no systems or mechanisms in place to recognise and acknowledge when people were in pain and required pain relief.

Feedback was regularly sought from people, relatives and staff. 'Residents' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. Incidents and accidents were recorded, but not consistently investigated. Where people had sustained harm, this was not always reported to the local safeguarding team.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapport with people and people responded to staff with smiles.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Dane House Care Home was not safe. Incidents and accidents were recorded, however, they were not regularly investigated or reported to the local safeguarding team when someone had sustained harm.

Management of people's care needs and skin integrity was poor and placed people at risk. The management of pain required improvement.

People told us they were happy living in the home and they felt safe. Recruitment practice was safe and protected people as far as possible

Inadequate



Is the service effective?

Dane House Care Home was not effective. Mental capacity assessments (MCA) were not completed in line with legal requirements and staff had not received training on the MCA 2005.

Lunchtime was chaotic with food being served to people who were fast asleep. Registered nurses had no oversight of how much people's ate and drank, and no guidance was available on how much people should be eating and drinking to remain healthy.

People spoke positively of care staff, but expressed some concern with staff training. Staff received on-going professional development through regular supervisions, but training that was specific to the needs of people was not readily available.

Inadequate



Is the service caring?

Dane House was not consistently caring. People spoke positively of the care they received; however, care practices did not always respect people's privacy and dignity.

People were not involved in planning their own care plans. Care plans did not reflect people's involvement, wishes or aspirations. Information on people's life history was not readily available.

Staff were seen to interact positively with people throughout our inspection. It was clear staff had built rapports with people and they responded to staff with smiles

Requires Improvement



Is the service responsive?

Dane House Care Home was not responsive. The delivery of care often suited staff routine, rather than people's individual preferences and choices.

People did not always have their individual needs met in a timely manner. The opportunity for social activity and recreational outings was limited. Activities were not meaningful to people living at the home.

Inadequate



Summary of findings

A complaints policy was in place and complaints were handled appropriately. Most people felt their complaint or concern would be resolved and investigated. Although some people felt their complaint would not be listened to.

Is the service well-led?

Dane House Care Home was not well led. The home did not regularly assess and monitor the quality of service or identify, assess and manage risks relating to people's health, welfare and safety.

Staffing levels were incorrectly calculated and did not reflect people's level of care needs and support required to safely meet their needs.

People spoke positively of the care, however, commented that staffing levels could impact on the running of the home. People had an awareness of who the manager was but not everyone could tell us they had met the manager and were aware of them.

Inadequate



Dane House 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 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.

The inspection took place on the 13 and 14 November 2014 and was unannounced. The inspection team consisted of two inspectors, a specialist nursing advisor and an Expert by Experience, who had experience of older people's care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared from the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection, we spoke with nine people who lived at the home, seven visiting relatives, the manager, regional manager, four registered nurses, three care staff and the chef. We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, the lounge and the conservatory. Some people had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the records of the home, which included quality assurance audits, staff training schedules and policies and procedures. We looked at seven care plans and the risk assessments included within the care plans, along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Is the service safe?

Our findings

People told us they felt safe. Comments included, “I feel very safe here.” “I definitely feel safe here.” Visiting relatives we spoke told us they felt confident leaving their loved one at Dane House Care Home. One relative told us, “I feel they are in safe hands.” Although people told us they felt safe, we found examples of care practice which were not safe.

At the last inspection in August 2014, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008. This was because risk assessments lacked sufficient guidance. During this inspection, improvements had not been made.

Individual risk assessments were in place, which covered areas such as mobility, continence care, falls, nutrition and pressure damage. They looked at the identified risk and included a plan of action. However, the risk assessments were basic and did not include sufficient guidance for care staff to provide safe care. One person had been assessed as being at very high risk of skin breakdown. Their individual risk assessment did not include measures required to manage or reduce this risk.

We looked at the provider’s management of skin breakdown. We were informed by the manager that no one had skin breakdown, or an open pressure ulcer (compromised skin integrity). We identified three people who did. Guidance was not available in their care plans on how to promote their skin integrity or to reduce the risk of it breaking down further. During the inspection, we observed three people sitting in the communal lounge. Good skin involves good management of continence. Periodically throughout the inspection, we checked on these people. We found they had not been assisted to access the toilet or change position in six hours. This increased the risk of skin breakdown, through sitting in a prolonged position and not receiving continence care.

Care records did not consistently tell us when people received support to meet their individual personal care needs. For example, records failed to inform when people were supported to access the toilet or receive assistance to change their continence pad. The nurses on duty were also unable to confirm when people had last received support to meet their toileting needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection in August 2014, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008. This was because we identified concerns with the monitoring of incidents and accidents.

There was a system in place for recording accidents and incidents. However, these were not consistently investigated. For example, one incident had not been thoroughly investigated to ascertain how a person had sustained harm. There were no recorded measures on how the risk of future harm was to be minimised. We also identified one person, who had sustained a hip fracture, but no incident form had been completed. These two incidents had also not been referred to the local safeguarding team.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were stored in line with legal requirements. Controlled drugs were all stored correctly and medication administration records (MAR charts) indicated that medicines were administered appropriately. Due to the individual healthcare needs of people, people had strict medication regimes and were prescribed medicines which had side effects that required monitoring. Understanding of people’s medicines and the possible side effects was not always understood by the registered nurses. For example, recordings reflected one person was often sick after having their medication. Their prescribed medicines had the side effect of vomiting. The registered nurses had not yet considered that the vomiting could have been caused by the medication.

People were at risk of not receiving medicine as they required it, such as paracetamol (PRN Medicines) due to lack of guidance and risk assessments. Eight people were prescribed PRN medication. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. Six people who received PRN did not have a PRN care plan detailing when the medicine should be administered.

People’s management of pain was not well controlled or managed appropriately. The provider provided care and support to many people living with dementia who were not able to verbally communicate their needs. Therefore they were unable to express verbally if they were in any pain or

Is the service safe?

discomfort. We found that pain assessments were not completed by registered nurses. Therefore, staff had no means of measuring, understanding and assessing people's pain levels. During the inspection, we overheard one person screaming out loud. We were informed by care staff that the person screamed out when being moved due to pain. No guidance or assessment of pain was available in their care plan. We also saw they were prescribed pain relief but this was not administered on a regular basis.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection in August 2014, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008. People were not protected from avoidable harm due to inappropriate moving and handling techniques. Care staff were observed moving a person from a wheelchair to an armchair by means of using a 'drag' lift. The 'drag' lift is any method of handling where the care staff placed a hand or arm under the person's armpit. Use of this lift can result to damage to the spine, shoulders, wrist and knees of the carer and, for the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit.

Care staff had a firm understanding that use of a drag lift was not safe. If the use of a drag lift was observed, care staff confirmed they would report it to the manager immediately. The manager told us, "Anyone seen using a drag lift, faces disciplinary procedures as this is extremely unsafe and places people at risk of harm."

During the inspection, we observed seven transfers (people being supported to move from a wheelchair to armchair with the support of appropriate equipment). Most of the transfers we observed were safe and attentive to the person. Care staff clearly explained to the person step by step what was happening. One person told us, "I feel safe when I'm in the hoist." However, we observed one transfer which was not safe. We found that where care staff stood

during the transfer placed the person at risk of falling. This meant the person had to stand for too long and their legs were seen to be shaking. After the transfer we spoke with the care staff involved. One staff member told us, "It was not very good but it was OK in the end."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, that the provider obtained references and carried out a criminal records check on them. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as well as their skills and qualifications. Nurses employed by Dane House Care Home and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date.

Training schedules confirmed all staff had received safeguarding training and staff we spoke with confirmed this. Staff had a clear understanding of abuse and felt confident that any allegations made would be fully investigated to ensure people were protected. Safeguarding policies and procedures were in place and were up to date and appropriate for this type of home. For example, the safeguarding policy corresponded with the Local Authority and national guidance. Although staff had received training in safeguarding adults at risk and spoke of the signs of abuse, we found safeguarding alerts were not always referred to the local authority when people sustained significant harm. For example, one person had sustained a skin tear whilst being moved from a wheelchair to a chair. The individual had experienced harm which had not been reported to the local authority.

This is a breach of Regulation 11 of the Health and Social Care Act 2008.

Is the service effective?

Our findings

People spoke positively about the home. Comments included, “I’m looked after.” “The carers are very good.” However, we found Dane House Care Home did not consistently provide care that was effective.

At the last inspection in August 2014, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008. This was because mental capacity assessments were not completed in line with legal requirements. Staff had also not received training on the Mental Capacity Act (MCA) 2005. Improvements had still not been made.

Staff were not working within the principles of the Mental Capacity Act 2005 (MCA). Staff members told us, that a large majority of people would be unable to consent to care and treatment, and had a mental capacity assessment completed. However, in the mental capacity assessments we viewed, it was not clear what decision was being made. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found mental capacity assessments did not record the steps taken to reach a decision about a person’s capacity. We asked the registered nurses to talk us through how they completed the mental capacity assessments. They were unable to tell us how they undertook the assessments and what steps they took. We were informed, “We were deciding on bed rails and acting in their best interest when giving care.” This told us mental capacity assessments were not decision specific and were not recorded in line with legal requirements.

Training schedules confirmed staff had received Deprivation of Liberty Safeguards (DoLS) training, but not specific MCA training. Care staff had a basic understanding of mental capacity and informed us how they gained consent from people. One care staff told us, “We offer people choices and give them information to enable them to make a decision.” Another member of staff told us, “We also monitor body language and facial expressions for signs of consent.” However, the staff’s, understanding of the MCA and completing mental capacity assessments was basic and not in line with legal requirements.

In March 2014, changes were made to the Deprivation of Liberty Safeguards and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty

have been authorised by the local authority, to protect the person from harm. During the inspection, we were informed by the manager that DoLS application were being made, but had not yet been submitted. We could not find individual assessments for people living at Dane House Care Home on how their freedom may be restricted and least restrictive practice could be implemented. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were complimentary about the food and the choice of food offered. One person told us, “The food is good and usually plenty of it. It’s nice to have a choice.” Another person told us, “The food is mainly good, if it’s not something I like I can ask for something different.”

We observed lunchtime on both days of the inspection. On the 13 November 2014, we observed lunchtime to be chaotic, with food still being served to people at 2.00pm. Four people had gone since breakfast at 8.00am until 2.00pm before receiving another meal. On the second day of the inspection, we found lunchtime to be much calmer, with food being served to everyone by 1.00pm.

The home had a large conservatory with tables laid out. On both days, no one ate in the conservatory. They remained in the lounge eating from small tables or in their bedrooms. No condiments were offered and the communal dining experience was not made available to people. The weekly menu was displayed in the lounge, but the daily menu was not made available for people to remind them what they would be having for lunch.

Where a need for a specialist diet had been identified we saw this was provided. For example some people were on a soft or pureed diet due to problems with swallowing. People received support with eating and drinking, but people had to wait for assistance. We observed care staff providing one to one support, giving explanations of what was on the plate and asking if people were ready for more before offering it. On both days of the inspection, we observed meals being placed next to people when the individual was fast asleep. One person’s meal was left to get cold as they did not awake during meal time. Eventually we saw a member of staff offer assistance to the person, so they could eat when they awoke.

Staff told us how they monitored what people ate and drank. One care staff told us, “We fill in people’s food and fluid charts every day.” We looked at a sample of food and

Is the service effective?

fluid charts. Staff had no oversight of people's daily intake. What people drank was not calculated daily and there was no guidance on how much people should be eating and drinking. We identified concerns with one person's nutritional intake. Documentation confirmed that their fluid intake was minimal, often only having a few sips of water a day. We have raised this under safeguarding procedures with the Local Authority.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff received on-going support and professional development. At the last inspection in August 2014, the provider was in breach of Regulation 23 of the Health and Social Care Act 2008. This was because staff members had not received a yearly appraisal or regular supervision meetings. Supervision is a formal meeting where training needs, objectives and progress for the year were discussed. We found improvements had been made.

Supervision schedules and staff we spoke with confirmed they received regular supervision (every two months) and appreciated the opportunity to discuss their concerns. Nursing staff also confirmed they had received clinical training and support.

We looked at the induction and training schedule for staff. Staff had received essential training, such as fire safety and first aid awareness. However, not all staff members had received training that was specific to the needs of people living at Dane House Care Home. For example, staff had not received training around mental capacity or dementia awareness.

People expressed some concerns about the training and support offered to new members of staff, or the way in which newer staff worked. One person told us, "I think they're very good, they do their best. Sometimes the new ones need to try harder." A visiting relative told us, "The carers are very nice, very kind, but they are in at the deep end, not shown what to do, just told."

Staff told us, and records showed that external health care professionals visited the home regularly. These included GPs, tissue viability nurses, dieticians and physiotherapists. Documentation confirmed staff referred people for specialist advice. However, we identified concerns with the home's management of people's healthcare needs until specialist advice was sought. One person had lost weight. A referral was made to their GP, however, their care plan did not provide any interim guidance to promote nutritional intake.

Is the service caring?

Our findings

People spoke highly of the care they received. One person told us, "It's a happy place, people are very friendly and the carers are very good, every one of them." A visiting relative told us, "The staff are very friendly." Although people spoke positively of the care they received, we observed care practice which was not caring.

At the last inspection in August 2014 the provider was in breach of Regulation 17 of the Health and Social care Act 2008. This was because we were concerned about people's privacy and dignity and how people were not involved in their care. We found improvements had been made, but people's privacy and dignity was not consistently maintained.

We observed some care practice which upheld people's privacy and dignity. For example, care staff always knocked before entering someone's bedroom. When moving people from a wheelchair to an armchair, care staff pulled a screen around the person to promote their privacy. Staff had an understanding of the principles of privacy and dignity. One staff member told us, "When providing personal care, make sure their door is closed." Another staff member told us, "I always ask if they are happy to receive care from a male staff member." We observed elements of good care practice; however, we found the principles of privacy and dignity were not embedded into every day care practice. We observed a nurse emptying an individual's catheter in the communal lounge. Their dignity was not respected and people sitting in the lounge could see what was happening.

Each person had their individual care plan. A care plan is something that describes in an accessible way the services and support being provided. They should be put together and agreed with the person involved through the process of care planning and review. However, there was no evidence people were actively involved in their care planning. Care plans did not reflect the person's wishes, aspirations or goals. Information was not available on how the person wished to receive their care, or what aspect of their care delivery was important to them. Care plans were reviewed monthly, but we could not see any confirmation the individual had been involved in their care plan review.

Information on people's personal life history was not readily available. Each person had a 'my choice/my

preference' booklet which looked at their memories, what was important to them and their cultural needs. However, we found these were rarely completed or contained very little detail.

This was a breach of Regulation 9 of the Health and Social Care Act 2008.

People were supported to maintain their personal and physical appearance. People had been supported to brush their hair and wear clothes of their choice. One lady proudly showed us her painted nails. Where required, people wore hearing aids, glasses and footwear of their choice. Staff were seen making sure ladies had their hand bags next to them and other items of importance as they provided comfort and reassurance.

People told us they were well cared for. One person told us, "They are very kind." Another person told us, "I'm very happy here." However documentation on when people received oral hygiene, bath or a shower recorded that often people would not receive a bath or a shower in 14 days. One person had only received one bed bath in 14 days. We also saw that people could go five days without receiving oral hygiene. The manager informed us, "Care staff should be recording in people's daily notes when a bath or shower is offered and why oral hygiene was not given." The sample of daily notes we looked at did not record when an individual received care or if personal care was offered. We could therefore not tell if people received regular support to bath or shower. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower.

This was a breach of Regulation 9 of the Health and Social Care Act 2008.

Despite the above concerns, we did see staff interacting with people in a kind and compassionate way. When talking to people, staff maintained eye contact and knelt down next to the person. Staff had clearly developed a rapport with people and people responded to staff with smiles. Staff we spoke with spoke positively of the home and confirmed they enjoyed their work.

People commented they could enjoy a laugh with staff. One staff member was observed teaching a person a couple of words in Spanish. The person was seen enjoying the interactions and was later seen talking the Spanish words again with the staff member. Staff members regularly brought in old newspapers for people who enjoyed doing

Is the service caring?

the crossword or Sudoku. One visiting relative told us, "Staff bring in old DVDs they think my loved one may enjoy. They brought in a football one the other week, they are very caring."

Is the service responsive?

Our findings

People commented they were well looked after by care staff. However, there was an acceptance by people living at Dane House Care Home they had to comply with how care staff wanted to do things.

At the last inspection in August 2014, the provider was in breach of regulation 17 of the Health and Social Care Act 2008. This was because we found it was common practice for people living with dementia to be partially dressed at 6am and then put back to bed. Improvements had not been made.

Care was not personalised to the individual. For example, people did not get up when they wished. Care staff told us it was not uncommon for people not to receive personal care until after lunchtime. During the inspection we monitored how long it took for people to receive personal care. We found that a large majority of people had still not received assistance with washing or dressing by 11am or 12pm.

People confirmed they often had to wait for assistance in the morning. One person told us, "It's not a question of when I want to get up." Another person told us, "I need to wait and be patient, which is what I'm doing now." A third person told us, "Well there are people who are more ill than me, so I have to wait my turn."

Records confirmed that the delivery of care was not personalised. For example, one person had requested to go to bed early evening. A member of staff informed the person they would be unable to assist as they were going to a handover meeting and this was more important. This reflected the delivery of care was centred on staff routine rather than individual preference and choice.

People did not always receive care when they needed it. For example, one person requested assistance to return to their bedroom at 2pm. At 5pm, the person was still waiting for assistance. The person told us, "Care staff know I go back to my bedroom at 2pm, but I've been waiting for a long time now. My bottom is starting to get sore." During the course of the inspection, the inspection team had to request staff assistance for people, as care staff had not responded to people's needs in a timely manner.

The provider employed a dedicated activities co-ordinator who worked three days a week. People spoke highly of the activities offered. One person told us, "The activities lady is very good, full of ideas; she comes to your room to have a chat. She makes you feel alive. And she does your nails if they need doing." Another person told us, "She reads the bible to me which I enjoy." However, we saw little organised activity on offer for people. We did see the activity co-ordinator spend time talking with people. However, people spent most of their time sitting in the communal areas with the television on. From our observations we could see that many were not really watching it. When the activities co-ordinator was not working, we found there was no opportunity for social activity or stimulation.

This was a breach of Regulation 9 of the Health and Social Care Act 2008.

We observed that people spent a considerable amount of time without staff being present. We sat in the lounge for 30 minutes and did not see a member of staff. People in the lounge had no access to call bells to summon assistance. One person's sitting position meant they were unable to see the television despite it being recorded in their care plan they enjoyed watching it.

People were seated around the walls of the lounge, the middle of which was used as a thoroughfare. For people who could view the television, this was regularly obstructed by care staff walking in front of them.

A complaints procedure was displayed in the entrance hall of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format. Most people told us they felt confident in raising any concerns or making a complaint. One person told us, "I'm happy to complain if I need to. I know who the manager is, I sometimes see her." However, some people did not feel confident that their complaint or concern would be resolved. One person told us, "If I had concerns I couldn't raise them with the manager, it's just a waste of time." The home had received four complaints since January 2014. One was still on-going, but documentation confirmed complaints were investigated and feedback was given to the complainant.

Is the service well-led?

Our findings

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The manager in post has not yet submitted an application to the CQC that has been accepted.

At the last inspection in August 2014, the provider was in breach of Regulation 22 and 10 of the Health and Social Care Act 2008. This was because we were concerned about staffing levels and the provider's framework for monitoring the quality of care provided. Improvements had not been made.

Staffing levels were not calculated appropriately. Staffing levels were calculated using a dependency tool called Care Home Equation for Safe Staffing (CHESS). This tool looked at each person's level of dependency (care needs) and calculated the required staffing numbers. The information to aid the CHESS tool was based on individual care plans and the assessed level of need documented in the person's care plan. The manager informed us that care plans were audited every month to monitor for any inaccuracies or missing information. We looked at the November audit which recorded that all care plans were accurate. We could not locate a date for when this audit was completed and the manager could not confirm when they completed the audit.

Within each care plan, we found inaccuracies. Information was wrongly calculated and people's levels of needs were wrongly assessed. One person had been assessed as having a low need in altered states of consciousness. However, this person had been experiencing periods of unresponsiveness. Therefore this person's level of need was not low. This information was fed into the CHESS tool which calculated staffing numbers; however, this information was incorrect. The audit of care plans had not picked up the errors we identified. The manager acknowledged that further work around assessing staffing levels was needed.

This was a breach of Regulation 10 and 22 of the Health and Social Care Act 2008.

The provider had increased staffing levels since our last inspection in August 2014. This was because we had found the staffing levels to be inadequate and placed people at risk. Despite an increase in staff we saw staffing levels were still stretched and the delivery of care was task based rather than personalised care. Staff continually told us, "We're too busy." Staff working 12 hour shifts, did not receive a break until eight hours into their shift. This placed staff at risk of exhaustion. The manager had not identified that staff were not receiving regular breaks or that people were not receiving care in a timely manner or personalised care.

This was a breach of Regulation 22 of the Health and Social Care Act 2008.

The culture and values of the provider were not embedded into every day care practice. The manager told us, "The vision of the home is looking after the resident. This is their home. When I first started working here, the culture was negative within the home, but I've been working on that and improving that." Staff we spoke with did not have a strong understanding of the vision of the home and from observing staff interactions; staff did not always work in a team. Although staff spoke positively of the culture and how they all worked together as a team, this was not observed in practice. For example, one staff member requested assistance with supporting people to eat and drink. Another staff member was heard declining to assist as those people were not on their allocated floor. During the inspection, we also observed two members of staff who were upset and crying.

Communication and leadership was not clearly defined in the home. On a daily basis, we were informed that staff deployment throughout the home was organised by the registered nurse and senior carer on duty. The lunch service was chaotic with staff not receiving adequate support. The manager acknowledged it was chaotic during this period, but we did not observe senior staff providing leadership or overseeing the situation.

There was not an effective quality assurance framework in place. Every day the manager completed daily checks. These looked at the environment, how people looked, records, toilets free from clutter and speaking to people. The daily checks did not record who the manager spoke with or their feedback, what records were viewed and any errors identified. The daily check on the first day of our inspection recorded the bathrooms and toilets were free

Is the service well-led?

from clutter. We identified two bathrooms that had hoists and commodes stored in them and therefore were not free from clutter. We therefore questioned the accuracy of the daily checks.

The home received regular quality monitoring visits from a regional manager and managers of other homes. These audits looked at the home's medication practices, documentation and health and safety. We looked at the October 2014 audit. The audit identified concerns with the recording of food and fluid charts. Despite a concern being identified, we found that improvements had not been made following the audit.

This is a breach of Regulation 10 of the Health and Social Care Act 2008.

Systems were in place to seek the views of people, relatives and staff. Staff meetings were held on a monthly basis and we looked at a sample of minutes which confirmed this.

These provided staff with a forum to air their views and provided opportunities for staff to contribute to the running of the home. Staff commented that they found these meetings useful and could raise concerns. One staff member told us, "The staff meetings cover everything and are very informative."

The provider was working in partnership with a local dementia organisation. The organisation provided workshops and guidance to care staff on supporting people living with dementia. The organisation had developed an on-going programme of work and actions to complete to improve the quality of care and recordings within the home. The action plan was in the process of being completed by the manager and staff. Staff spoke positively of the input and looked forward to attending training sessions and learning about the importance of dementia care

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of service users and others. Regulation 10.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration. Regulation 14 (1) (a) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable systems in place to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced persons employed to meet the needs of the service users. Regulation 22

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

The registered person did not protect service users against the risks associated with the unsafe use and management of medicines. Regulation 13

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

The registered person did not make suitable arrangements to ensure that service users are safeguarded against the risk of abuse. Regulation 11

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	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of carrying out of an assessment of needs of each service user and the planning and delivery of individual needs.</p> <p>There was a lack of risk assessments in place that ensured service users were receiving safe appropriate care</p>

The enforcement action we took:

A warning notice has been issued. The service is to be complaint within one month of receipt of the warning notice