RMH (Wispers) Care LLP

Wispers Park Care Village

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 22 and 23 October 2014 with a pharmacy specialist visiting on the 27 October 2014. The inspection was a comprehensive inspection which was brought forward due to concerns being raised about the quality of care being provided. This inspection was unannounced. The previous inspection took place on 18 June 2014 and found the home was complying with the outcomes we inspected at that time.

Wispers Park Care Village is a nursing home providing personal and nursing care for up to 55 older people. At the time of our inspection 26 people were living at the home. The home is divided into separate units with three of these, Oak, Beech and Willow in use at the time of inspection. The home is a modern addition to an older building which includes a bistro and communal facilities. The home is part of a larger complex of buildings which provides more independent living accommodation on the rural outskirts of Haslemere in Surrey. At the time of our inspection there was no registered manager at the home. A management team and acting manager were in place whilst a new manager was being recruited and applying to register.

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the

Summary of findings

service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we spoke with 10 people, five relatives and 10 members of staff. We also spoke with the acting manager and other representatives from the provider's organisation. Before the inspection we reviewed the information we hold about the service and took into account cocnerns we had received. We spoke with social workers and nurses who had visited the home as representatives of health authority.

People expressed contradictory views about how safe they felt at the home. Whilst some people felt very safe, others said they felt unsafe and that the staff did not always protect them from harm. Staff did not always know how to protect people from harm or the risk of harm. Staff had not acted to identify and respond to possible abuse. This is a breach of Regulation 11 (1) (a) (b) (3) (d) of the HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse.

Some people said their movement was restricted because of safety measures such as key pad locks in some areas of the home. When these restrictions were in place people had not had their ability to make their own decisions or their best interests considered. People and their relatives had not been consulted about their care. Their consent to their care and treatment had not been sought or recorded. This meant that people could not be assured that the staff were acting according to their wishes. These are breaches of Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment.

The home did not have suitable quantities of staff with the required skills and experience. People told us they had to wait for help with their personal care. People also said there were not enough staff to help them go out as often as they would have liked. Not all the staff knew about people's care or their individual needs. Staff training and supervision was inconsistent which led to some staff not receiving appropriate training to care safely for people. This is a breach of Regulation 22 of the HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.

Incidents and accidents had not always been responded to in a way that meant the staff could take actions to prevent them happening again.

People had not always been properly assessed, had their care planned or delivered to meet their individual needs. The staff did not always have access to the most up to date information about people's needs. This meant people were at risk of receiving inappropriate or unsafe care.

People were at potential risk in the event of a fire because the provider had failed to act on the requirements of two fire authority reports. The staff had not been trained to protect people in the event of a fire.

The examples above are breaches of Regulation 9 (1) (a) (b) (i) (ii) (2) of the HSCA 2008 Regulations (Regulated Activities) Regulations 2010 Care and welfare of people who use services.

People were not having their nutritional needs met. Staff did not always know people's dietary needs or offer people suitable choices. People were not always being assisted to eat and drink and their food and fluid intake was not effectively monitored which put them at risk of malnutrition and dehydration. This is a breach of Regulation 14 (1) (a) (c) HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs.

Medicines were not managed safely, we found medicines stored incorrectly. It was not always clear from the records whether people had the medicines they were prescribed at the right times or in the right doses. The arrangements for treating people with the correct doses of medicine for their diabetes were inconsistent. Several people told us they had been given their medicines much later than the prescribed times. This is a breach of Regulation 13 of the HSCA 2008 (Regulated Activities) Regulations 2010 Management of Medicines.

Where people had complained the provider had not dealt with these according to the complaints procedures. People, their relatives and staff had not been asked their views about the quality of the care or about improvements they would like to see.

Summary of findings

The provider had not managed the risks to people that had been identified. When people were losing weight the staff had not taken action to ensure they had the care and treatment they needed to prevent their health deteriorating further.

The provider had known there had been deterioration in the service and care provided for some time but had failed to take robust and effective action until the two weeks prior to this inspection and during the inspection. The examples above are breaches of Regulation 10 (1) (a) (b) (d) (i) (ii) (iii) HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of the service provision.

People had contradictory views about how caring the staff were. People said sometimes the care they received depended on the staff available to care for them. We observed and were told about instances where staff did not treat people respectfully or in a caring manner.

People's dignity and privacy were not always being protected. Staff entered people's room without knocking and waiting for people to respond. People were not always receiving the personal care they needed to maintain their dignity. People or their relatives had not been enabled or included in making decisions about their own care. They had not been encouraged to express their views about what was important to them. The examples above are breaches of Regulation 17 (1) (a) (b) (2) (a) (b) (c) (I) (ii) (d) (f) HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services.

The home had not been designed or adapted to meet the needs of everyone who had been admitted, especially people who were living with dementia. There were no adapted signs indicating where people could find the toilet for example. This is a breach of Regulation 15 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises.

Some people made comments about how kind the staff were and how the staff response to their call bells was usually 'excellent'. We observed some very kind interactions when staff assisted people with their needs in a caring and thoughtful way.

The new management team had started to identify the shortfalls in the care and service and had begun to take actions to address these. However, at the time of this inspection there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We recommend that the service considers how they could improve the activities provision to suit the individual needs of the people living at the home.

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

The home was not safe. There were not always enough staff to meet people's needs.

People were not protected from unsafe care or abuse because staff had failed to recognise potential abuse and did not respond appropriately according to the homes procedures or those of the local authority.

Medicines were not managed safely and appropriately.

People had not been protected from potential risks in the event of a fire.

Equipment had been maintained safely and safe recruitment procedures had been followed.

Is the service effective?

Inadequate

The home was not effective. People had not been effectively assessed or care delivered appropriately to meet their individual needs and choices.

Staff had not received appropriate up to date training and did not have an understanding of the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLs). Staff had not been effectively supervised or supported to carry out their roles.

Staff did not always understand people's nutritional needs or provide them with appropriate assistance. People's weight, food and fluid intakes had not always been monitored or effectively managed placing them at risk of malnutrition and dehydration.

People's health needs were not effectively monitored or met.

Is the service caring?

Requires Improvement

People were often, but not always treated with care, dignity and respect or their privacy protected.

Staff did not always interact with people in a respectful or positive way in particular at mealtimes. There were individual examples of staff caring well for people.

People told us most staff were caring but they were not always consulted about their care or the daily life of the home.

Is the service responsive?

Inadequate

The home was not responsive to people's needs.

People's needs had not been assessed, planned for, or delivered in response to their needs, preferences or wishes. Staff did not have access to the most up-to-date information about people's needs.

Summary of findings

There were a range of activities available for people to continue with their individual interests and hobbies however, these were limited.

Relatives were able to visit their family members at any time. Not everyone had their requests for care responded to a timely way.

People felt able to complain if they needed to but complaints were not always responded to appropriately.

Is the service well-led?

Inadequate

The home was not well-led.

People and their relatives told us there was a lack of good communication in the home and they were not invited to share their views.

The values of the home were not being delivered in practice and there was not a robust quality assurance process in the home. The provider had not taken timely action to identify and put right issues that affected people's care and safety.

Documentation relating to the management of the service such as accident and incident records were not up to date which affected the ability of the home to manage people's care safely.

Wispers Park Care Village

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 22, 23 and 27 October 2014 and was unannounced.

The inspection team on the 22 and 23 October consisted of three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had a background in care homes and dementia care. A pharmacy inspector visited the service on the 27 October 2014.

We brought forward this comprehensive inspection because we had concerns raised about the service by social services, a relative and a member of staff. Before the inspection we reviewed information we held about this service including any statutory notifications sent to us by the provider. We spoke with social services, representatives of the health authority and had email contact with the fire authority before and during this inspection.

During the inspection we spoke with 10 people who used the service, five relatives and 10 members of staff. We also spoke with the acting manager, and five representatives of the provider's organisation. We used periods of observation to gain an understanding of people's experiences and the interactions between staff and people. We reviewed records that related to all aspects of the service including eight care plans documents, medicines records, management system records and other relevant documents. We saw and spent time in all areas of the home that were in use.

Inadequate

Is the service safe?

Our findings

Two people told us they did not feel safe in the home, due to the behaviour of one person who was living with dementia. We saw incident reports where people had been harmed on more than one occasion by this person. These had not been managed safely or reported as potential abuse to the appropriate authorities. The home had guidance for staff to follow to protect and safeguard people from abuse and there was a copy of the local authority's guidance. However, the staff were not able to describe how they would protect people from abuse or where they could access this information.

We saw that staff were not able to manage behaviour that challenged and potentially abusive. For example, we saw an incident during lunch where one person left their dining table and threatened two others at their table. Staff did not act to protect people from the risk of avoidable harm from this person. Staff did not know where they could find guidance to advise them how to protect people from abuse and had not implemented the safeguarding procedures to protect people. Staff told us they had not been trained to manage people whose behaviour challenged others or those living with dementia. People had not been protected from the risk of abuse or avoidable harm. This was because staff failed to recognise that incidents between people may have constituted abuse. The staff had failed to report these concerns and to take appropriate actions to protect people. The provider failed to take steps to identify the possibility of abuse. They did not respond appropriately and staff neglected to act which placed people at risk of harm. This is a breach of Regulation 11(1) (a) (b) (3) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that there were not always enough staff. One person on Beech unit said, "Sometimes when you ring the bell they don't always come and there's only one looking after the floor" This unit had one member of staff who cared for five people. Two of these people required two staff to provide care for them. If the member of staff required assistance they would call staff from other units which then impacted on the care for people in those areas. Five other people told us they had to wait sometimes up to half an hour for staff to come and help them to use the toilet which caused them anxiety. Two of these people said that on occasions the staff had taken so long to come it had led to them being incontinent which was not usual for them and caused them distress. One other person said they had a health condition which meant they needed to receive their food at certain times. They said that because there was not enough staff they had not always received their food on time which had caused them to be in pain. Staff told us the lack of adequate staff numbers meant they were often under pressure to try to deliver all of the care safely to people.

It was unclear how many staff were needed to meet people's needs. This was because the provider had not used a system which allowed them to assess the number of staff needed to deliver all aspects of care for people at all times. We were told by the provider's representative that there was one nurse and six care staff needed to meet people's needs however the acting manager told us that there should be two nurses and seven care staff. During the inspection the staff numbers increased between day one and day two and staff continued to tell us there were too few staff to meet people's needs safely. The lack of adequate staff to meet people's needs at all times is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not always managed safely. When people had body creams prescribed the staff had not recorded that these were being given to people. The staff were unable to tell us or demonstrate that these creams were being administered or applied as prescribed. People who required varied doses of medicines depending on their regular blood test results had been tested. However, the results had not been received by staff from the G.P. They did not follow this up which meant people continued to receive a dose that may not have been appropriate to their condition. Information the staff needed to give people their medicines at the right time, in the right dose and to meet each person's needs was not always available. There was no guidance in place to inform staff about what action they should take in an emergency if certain prescribed medicines did not work and the person's condition deteriorated.

Prior to this inspection, social services, health authority representatives and a community pharmacist had raised concerns about the way medicines were being managed in the home. The provider had started to manage and make improvements, however, we found not all of the medicines were being stored, administered or recorded safely. For

Inadequate

Is the service safe?

example the storage of controlled medicines (Controlled Drugs CD's) cabinet was not as securely fixed to the treatment room wall as to comply with The Misuse of Drugs Act (Safe Custody) regulations (1973). Whilst the log, or register, where staff recorded the controlled medicine was consistent with the stock remaining in the records further controlled medicine was found in a medicine trolley that had not been accounted for, this was also a breach of the Act stated above. This was a risk because staff were unable to fully account for the amount of controlled medicines that were in the home or monitor their safe use. The continuing failure to safely manage medicines is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had not been protected from potential risks in the event of a fire. This was because the requirements of two fire reports had not been fully implemented. Staff did not know what to do in the event of a fire and could not describe to us what action they would take to protect people. There were no up to date personal emergency evacuation plans in place for people. This is a breach of Regulation 9 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were recruited using a safe and effective recruitment process which ensured they were fit to work with people. The recruitment system was completed by a team at the provider's head office. Checks were completed prior to staff starting work and nurses were registered with their professional bodies. Staff told us these checks had been completed before they started to work at this home.

The equipment the staff used to assist people to move around such as wheelchairs and hoists had been serviced and had been well maintained. We saw certificates and reports which demonstrated that the equipment, such as fire extinguishers, hoists and lifts had been serviced, maintained safely and were fit for the intended purpose.

Inadequate

Is the service effective?

Our findings

The majority of people told us that overall they received good care. However, they raised concerns that not all of the staff knew their needs. One relative told us that because staff did not know how to insert a hearing aid properly the person had suffered an injury on more than one occasion. This person's care plan did not contain any instructions for staff in how to insert the hearing aid correctly and staff said they had not received training to carry out this task. Where other people used hearing aids there was also a lack of guidance for the staff to follow to deliver effective care.

People praised some individual staff that cared for them and said how hard they worked. However, people also said that staff constantly changed and as a result they didn't know them and the staff didn't always know their needs. Three relatives said they were concerned about the use of lots of agency staff who did not know their family's needs. One comment said, "That there seemed to be too many agency staff and whether they had proper training was questionable." Another relative said, "The girls who come in sometimes don't know what my mother likes and they seemed to be lost (not knowing what they are doing) when they come to help her have a wash".

Some pre-admission assessments had not been completed and therefore people and those that matter to them could not be assured that their needs would be effectively met. The care plans did not included personalised details regarding how people preferred or chose to be supported such as the times they liked to get up in the morning or go to bed. Three members of staff we spoke with did not know the needs of the people they were caring for; they were unable to describe people's preferences regarding their routines. Two members of staff did not know who had diabetes and therefore people were at risk of receiving ineffective care. Staff offered people sugar to put on their pudding at lunch time and these were staff who were unable to identify the people who were diabetic. The other member of staff said they did not know one person's needs and they had not read their care plan.

Although people told us they received appropriate healthcare support and there were regular visits from a G.P. we found people's healthcare needs were not always being met by staff. One person had wounds to their legs that had dressings applied. There were no wound care plans in place and therefore, staff were unaware of the progress of whether the wounds were healing or how often the dressings should be changed. One person had been seen by a G.P on the 20 October 2014 and the outcome recorded in their file was to continue with food supplements. There were no details of the supplements recorded on the care file. This demonstrated that staff were not always ensuring that people were receiving care that was appropriate and met their individual needs or their welfare and safety. These examples of ineffective delivery of personalised care are a breach of Regulation 9(1) (a) (b) (I) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person who used a wheelchair was being helped by staff to move from the dining room into the lounge. We commented to them that the person's foot was trailing on the ground because the staff member had failed to ensure the person was safely using the footplate. The member of staff said they had received training in how to move people safely in their last job but not whilst they had worked at this home. The provider's representative who also observed this incident told us they would have expected the staff to know how to care for the person effectively but that staff training was not up to date.

One person who was living with dementia was looking out of the window for long periods and had been asking to go out by approaching the door repeatedly. One member of staff had been asked to provide one to one support for them. They did not interact with the person and when we asked them they did not know if they were able to support the person to go outside. They told us they had not received any training in dementia and did not know this person's individual needs. Other staff told us the lack of training in how to provide effective care for people living with dementia caused them anxiety as they were expected to deliver care to people without the appropriate knowledge or skills. The training records showed that staff had not received training in the core skills they required to carry out their roles effectively including how to move people safely, how to care for people with diabetes and for those living with dementia. Staff told us they had not all received training in protecting people from abuse. This showed us the provider was not always providing staff with the skills and knowledge they needed to provide safe or effective care. The lack of suitably qualified, experienced and skilled staff to meet people's needs is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Staff told us they had not had regular supervisions where they were able to discuss their role and responsibilities, the standard of their work or their training needs. The acting manager confirmed to us that staff had not been supported effectively and they had identified that staff supervisions had not always taken place. This lack of supervision meant that staff were not clear about their roles and they were not supported to effectively provide care and treatment. This is a breach of Regulation 23(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The majority of people said the food was generally good. However, we found that people had not been consulted about their food likes, dislikes and needs until during the inspection. One person said they had questioned a member of staff about the nutritional quality of the food in relation to their dietary needs. They told us that a member of staff had said to them "We don't care about the nutritional value, as long as people eat it" Another person said, "They don't invite input into the menus". Staff did not always understand people's nutritional needs or provide them with effective assistance. Staff who were serving lunch in one unit said they did not have enough information or training to provide people with a suitable diet from the foods that were provided from the kitchen. The kitchen staff said the staff should know what people could eat although they did not have information about people's individual food preferences.

People's weight, food and fluid intakes had not always been monitored or effectively managed when they had been identified as being at risk of malnutrition and dehydration. One person had been assessed as at risk of dehydration and therefore they required their fluid intake to be monitored daily starting on the 21 October 2014. On that day the staff had recorded they had 650 millilitres of fluid and on the 22 October, 730 millilitres. We asked the acting manager who is a nurse to make a professional assessment of this person's hydration status. They said they were, "a little bit dehydrated" and then called the GP to come and look at them. Another nurse told us they would expect someone at risk of dehydration to have at least 1000 millilitres of fluid a day. This does not reflect the professional guidelines in 'Water for health' complied by the Royal College of Nursing and the National Patient Safety Agency which recommends a minimum fluid intake of 1500 millilitres per day to maintain health and wellbeing.

Where people required staff to monitor their food intake these charts were incomplete and did not demonstrate that people were given enough to eat. We saw records which showed that when people had lost significant weight no effective action had been taken to report concerns or to refer people to health care professionals for advice or treatment. In two instances we saw that although people had been refusing food and their weight had dropped by up to five kilograms between July and September the care plans recorded that their appetite was good. The staff had failed to respond to these needs and make appropriate referrals to health professionals. These examples of the provider not ensuring that people were protected from the risk of dehydration and malnutrition are a breach of Regulation 14 (1) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The failure to reflect published guidance as to good practice in relation to people's care and treatment is a breach of Regulation 9 (1) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found the home was not meeting the requirements of DoLS. People's need for a best interest decision where they may have lacked the capacity to make their own decisions had not been considered and in some cases people's freedom was being restricted without safeguards in place. No applications had been made to the appropriate authority to seek the relevant assessments prior to the inspection. One application was made during the inspection after we had raised concerns about one person who was living with dementia frequently seeking to leave the unit. Another person living in a key pad locked unit told us the staff had said they could not go to meet their relatives downstairs when they visited as it upset those people with dementia. The staff told us this person had capacity to make their own decisions but this had not been formally assessed and they were having their freedom to move around restricted. Not all staff we spoke with had an understanding of the Mental Capacity Act (MCA) 2005 and how to ensure the rights of people who lacked capacity to make decisions as they had not received appropriate training. These examples show that people's consent had not been sought to their care or treatment and

Inadequate

Is the service effective?

their rights under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards had not been considered. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who were living with dementia were accommodated in units with people who did not have dementia. We observed people living with dementia walking around the units without purpose. One person said they were looking for their room and kept asking us where that was. Another person kept asking staff where they could sit. People's needs were not being met effectively by the design, adaptation and decoration of the building. People had been admitted to the home without effective pre-assessments which would have determined if their needs could be met within the environment. The acting manager told us that in their opinion the home had not been designed or adapted for people living with dementia and some people should not have been admitted. These people had been admitted when the registered manager, who was no longer in day to day control, had been managing the service. The home did not have the decoration or signage that would have enabled people living with dementia to find their way to a toilet or their bedrooms or to be as independent as possible. This is a breach of Regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service caring?

Our findings

Overall people said the staff were mostly friendly; they worked hard and were always busy. We found through observation that whilst the majority of the staff were caring this was not always the case.

People told us that the lack of staff affected their ability to care for them. One person said, "There are not enough staff to spend quality time with us." Another person said, "They are always busy with the basics". One relative said their family member needed "Tlc (Tender, loving care) and help to adjust" to her new situation and this was not happening as the home did not have enough staff to provide this care.

During lunch time we observed one person who needed help to eat their meal. There were no members of staff in the dining room at the time and they asked another person sitting alongside to help, which they did. When a member of staff entered the dining room they told the person who was helping, in a loud and harsh voice that they should stop, that they were not allowed to 'feed' other people. The person was upset at how they had been spoken to and asked the staff to apologise to them however they did not apologise. This showed a lack of respect and compassion. We saw staff serving meals to people without speaking to them, making eye contact or asking people if they had what they needed. Later in a lounge we saw another member of staff walk past one person who was asking for help. This member of staff did not stop to enquire if they could help or seek other staff to assist this person.

We saw three members of staff at different times helping people without talking to them or explaining what they were doing or giving people a chance to express themselves. On one occasion a staff member helped a person to move from their wheelchair into an arm chair without speaking to them. Once the person was seated they started chatting to other people around them. The staff member took the wheelchair away then returned and approached the person's arm chair from behind and pushed it forward without any explanation. The person expressed surprise as they had not expected this. The staff member did not communicate with the person concerned before the chair was moved and did not respond or comment to the person. This showed a lack of care and compassion for that persons feelings. We observed one person who was in a lounge when we were first shown around the home who required urgent personal care. Staff had failed to notice or respond which compromised their dignity.

People told us they were not always encouraged to give their opinions, for example they had not been involved in the menus or the choice and frequency of activities. People said they had not been involved in planning their own care or making decisions about their treatment. People said the exception to this was the activities organiser who did encourage their participation and seek their views about their choices and two people who said they had asked the chef for specific menu choices.

Most people we spoke with said the staff respected their privacy and that staff knocked before entering rooms. However, one person said they spent most of the time in their room, with the door open and often staff entered their room and ensuite bathroom without knocking and waiting for a response. One other person told us staff rarely knocked on their door before they entered. We saw a member of staff walk into a closed bedroom without knocking. These examples of a lack of care, compassion, respect, dignity and privacy are a breach of Regulation 17 (1) (a) (2) (a) (b) (c) (i) (ii) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Whilst some of our observations and some of the feedback we had from people was negative about the care we saw some individual examples of staff displaying care and compassion for people. Some staff took time to talk with people and listen to them, explain what was happening and offer choices of the meals and snacks available. We saw staff using appropriate contact to reassure people like holding their hands. Three people expressed their pleasure to us during a discussion with two members of staff. They said, "We are having a lovely chat". We observed one member of staff responsible for activities engaging people in pleasant conversation and encouraging them to join in a sing along which people did with enthusiasm as we heard them singing loudly.

Inadequate

Is the service responsive?

Our findings

Most people told us they were unaware of their care plans and asked us to speak to their relatives about this. Relatives we spoke with told us they had not been involved in the planning of the care or asked to contribute their ideas on how their family members should be cared for. They did not know if care plans were in place. The care plans we saw did not contain evidence that people or their relatives had been involved in decision making about their care or treatment.

People had not been involved in contributing to the assessment of their needs or the planning of their care or treatment. People had not been consulted about how they could be enabled to remain as independent as possible or how they wished to be cared for. The care plans had not all been updated to reflect people's current care and health needs and where they had been reviewed people or their relatives had not been encouraged to contribute to the reviews. Staff were not all able to describe people's needs or how they should respond to those needs.

The care plans rarely contained personalised information that described to staff how people liked to receive their care, their preferences or their interests. Where there were examples of personalised care planning the staff had not read these plans so they were unable to respond to people's individual preferences and wishes. One member of staff said, "I don't usually work on this unit and I haven't read the care plans so I don't know what care people need here". Another member of staff said, "I haven't read people's care plans and I have to ask other staff." These examples of a lack of people's involvement in planning and decision making regarding their own care and treatment is a breach of Regulation 17 (1) (b) (2) (b) (c) (I) (ii) (d) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with people about how they could make a complaint and if they felt confident to do so should the need arise. People said they would raise issues with the staff or manager, they did not tell us that they would have any concerns in doing this. One relative told us they had made a complaint several times over the previous five weeks. They said they were not satisfied with the lack of a response or with the lack of action to address their complaint. We saw a record of the complaints that people or their relatives had made. These records were incomplete and did not indicate how people had been responded to, what actions had been taken and whether the issues had been resolved. This was not consistent with the homes complaints policy. The acting manager told us that complaints had not been managed in line with their policy and they were reviewing these to take any actions required. This is a breach of Regulation 19 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the people we spoke with told us they had access to some activities during the three days a week a member of staff was available to organise these. People said for the rest of the week there was a lack of activities to keep them interested and occupied. All the people we asked who choose to take part in the group activities said they were various activities in the home but there were very few opportunities to go out due to the need for extra staff. We found that for people who chose not to take part in group activities or who were living with more advanced dementia there was little individual activity to prevent their social isolation and encourage them to remain involved in their community. **We recommend that the service considers how they could improve the activities provision to suit the individual needs of the people living at the home.**

One person expressed pleasure that they had been supplied with a special table to continue their hobby in their room. There were two people who played the piano at a high standard. There was an electric piano organ and an upright piano available for them to use. We heard both instruments being used by people during the day.

Inadequate

Is the service well-led?

Our findings

The registered manager was no longer in day to day control of the home at the time of this inspection. Since the inspection visits the provider has notified us that the registered manager will not return to the service. A new manager has been appointed and the provider told us they were aware the manager was required to submit an application to register with the CQC as soon as possible after they take up their role.

The provider put a new management team in place two weeks prior to our inspection following concerns that were identified by social services, the health authority and the CQC. The management team had begun to identify shortfalls and had developed an action plan. In the same week as this inspection the provider had put in a new acting manager and other representatives with the stated intention of these senior staff implementing the action plan and improving the home.

People and relatives we spoke with had not all been made aware that the registered manager was no longer at the service. One relative said if they had concerns they would approach the manager. They were unaware the manager was no longer available. This meant people and their relatives had not been informed about who they could approach if they had questions, concerns or complaints or required information.

There has been a lack of oversight by the provider in using their quality assurance systems to monitor and address the shortfalls in the service. There had been a delay in taking action to address the identified shortfalls. For example, the provider told us they had recognised the service had deteriorated but not taken action until two weeks prior to our inspection. The provider said they had realised that the registered manager responsible for making decisions about the service and the care at the home had not been reporting the concerns or the failings to the provider's representatives. The provider took action to address the failings in response to other agencies raising concerns about the standards of care and safety. The delays in the providers taking action had had an effect on the care people had received and put people at risk of unsafe or inappropriate care. This is a breach of Regulation 10 (1) (a) (b) (d) (I) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that the values and aims stated by the provider were not being delivered in practice. The staff did not know what the provider's values and aims were when they were providing care for people. People did not always have access to activities or therapies which were advertised as part of the service. People were not always living dignified or independent lives. The staff had not always ensured that people's physical, and social health needs were met.

The provider also stated as one of their services, specifically related to this home, that there were arrangements in place to meet the needs of people with diabetes. The arrangements such as screening, a healthy diet and exercise were not being delivered or offered to people with this condition at this home.

The provider had not assessed the staffing levels or the impact this was having on the outcomes for people.

The records related to accidents, incidents, complaints and people's health had not been audited which meant the provider had failed to identify that records were missing or incomplete. The provider had not audited accidents or incidents and they were unaware of all the accidents and incidents that had taken place. As a result of this they had not taken action to ensure people were protected from harm or that risks to people were managed.

People and their relatives said they had not been given opportunities to share their views about the service and care. People said they had not been consulted about their care. People made many comments about the quality of the care both negative and positive and they said they would have felt able to speak to the management but they had not been given this opportunity. Some of the relatives we spoke with commented on poor communication between themselves and the staff and that when they had raised issues or concerns these had not always been responded to in a way they would have expected.

The staff said that the 'culture' of the home had improved in the last two weeks and they felt they could speak to the acting manager and senior staff regarding their concerns. Staff said they knew who they would speak to, and where to find guidance if they needed to raise whistle blowing concerns about the work or conduct of other staff. Staff said they had not always felt able to express their views or raise concerns prior to the last two weeks.

The acting manager and the provider's representatives were open and transparent regarding the challenges they

Inadequate

Is the service well-led?

faced in improving and changing the home to provide safe, effective, responsive and well led care to people. These senior staff had started to take action to address the concerns including starting to train staff in protecting people in the event of a fire and safe medicines management.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services This is because the registered provider failed to make suitable arrangements to ensure the dignity, privacy and independence of people. People were not enabled to make or participate in making decisions related to their care or treatment. People were not always treated with consideration and respect. People were not enabled to express their views as to what is important to them in relation to their care or treatment. People had not been given appropriate opportunities, encouragement or support in promoting their autonomy, independence or community involvement.

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 This is because the registered provider failed to have suitable arrangements for obtaining and acting in accordance with people's consent in relation to their care or treatment.

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 This is because the registered provider failed to protect people from the risk of inadequate nutrition and dehydration: People did not always have a choice of suitable food; people were not always supported to have sufficient food and drink.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse This is because the registered provider did not have suitable arrangements to ensure that people were protected against the risk of abuse: Reasonable steps had not been taken to identify abuse and prevent it before it occurs, respond appropriately to allegations of abuse. Where restraint had been used there were not suitable arrangements to protect people from this being unlawful.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines This is because the registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by failing to have appropriate arrangements for obtaining, recording, storing, handling, safe keeping, dispensing, and safe administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises This is because the registered provider failed to ensure that the premises were of suitable design and layout for people who were using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints This is because the registered provider failed to operate an effective complaints system for identifying, receiving, handling and responding appropriately to complaints made by people and others: Failing to investigate complaints and wherever possible resolve these to people's satisfaction.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing This is because the registered provider failed take appropriate steps to ensure that at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff for the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff This is because the registered provider failed to have suitable arrangements in place to appropriately support persons employed to enable them to deliver care and treatment to an appropriate standards.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Because the registered provider had failed to carry out assessments of people's needs, failed to plan and deliver care and treatment that met people's needs and ensured their welfare and safety.

The enforcement action we took:
We issued a warning notice to the registered provider on the 31 October 2014 in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have set a timescale of 29 December 2014 by which the registered provider must address this breach.

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 providers How the regulation was not being met: People who use services were not protected against the risk of inappropriate or unsafe care. Because the registered provider had failed to operate an effective system to enable them to: regularly assess and monitor the quality of the service, identify, assess and manage risks related to health, welfare and safety of people using the service, have regard to complaints and views expressed by people and others.

The enforcement action we took:
We issued a warning notice to the registered provider on the 31 October 2014 in relation to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have set a timescale of 29 December 2014 by which the registered provider must address this breach.