Care Quality Commission

Greenswan Consultants Limited

Pinelodge Care Home

Inspection report

Graveley Road, Stevenage, Hertfordshire,
SG1 4YS
Tel: 01438 721417

Date of inspection visit: 9 April 2015
Date of publication: 19/06/2015

Ratings

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

Overall summary

This inspection was carried out on 9 April 2015 and was unannounced.

Pinelodge Care Home provides accommodation and personal care which include nursing care for up to 140 older people. There was a 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 legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

When we last inspected the service on 30 September 2014 we found them to be meeting the required standards. At this inspection we found that they had not continued to meet the standards.

Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority in relation to people who lived at the

Summary of findings

service and were pending an outcome. Some staff were not fully aware of their role in relation to MCA and DoLS and how people were at risk of being deprived of their liberty.

People living at the home and their relatives told us they did not always get their needs met. This included personal care needs and health care needs. Personal care was task orientated as staff could not detail people's needs and restriction on time due to staffing deployment and absence meant that it was sometimes task orientated.

Medicines were not always managed safely. Staff had not received up to date training or supervision of their practice to assess their competency. Records and stock of medicines were inaccurate.

The deputy manager told us that staff training was completed if they identified a staff member as needing it. As a result staff knowledge in some areas was limited and we observed poor practice, particularly in relation to moving and handling, pressure care and wound management where staff need for training had not been appropriately identified or delivered. Staff supervision meetings had recently started.

People's nutritional and healthcare needs were not always met. Care plans required updating, as staff were not always aware of people's specific needs and health conditions.

The management in the home had been working on improving systems to monitor, assess and improve the service. However, some areas for improvement had not been identified or resolved.

The dementia care unit had been improved. People were being engaged in activity and were supported when they became anxious.

At this inspection we found the service to be in breach of regulations 9, 10, 12, 13, 14, 17 and 18 of the Health and Social care Act 2008 (Regulated activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?
The service was not safe.

People were not supported to ensure their needs were met safely.

People's medicines were not managed safely.

Inadequate

Is the service effective?
The service was not effective.

Staff did not receive training relevant to their roles and did not have their competency assessed.

People were not consistently supported to eat and drink sufficient amounts to help them maintain a healthy balanced diet.

People were supported appropriately in regards to their ability to make decisions. However, staff were not clear in relation to MCA and DoLS.

Inadequate

Is the service caring?
The service was not caring.

People were treated with kindness but their privacy and dignity was not promoted.

People who lived at the home and their relatives were not consistently involved in the planning and reviewing of their care.

Inadequate

Is the service responsive?
The service was not responsive.

People who lived at the home and their relatives were confident to raise concerns.

People did not always receive care that met their individual needs and care plans were not always clear.

The provision of activities on the dementia unit was good, however, other units required improvement.

Requires Improvement

Is the service well-led?
The service was not well led.

The systems in place to monitor, identify and manage the quality of the service had not identified or resolved issues found on our inspection.

Most people who lived at the service, their relatives and staff felt the management and leadership had improved.

Inadequate

Pinelodge Care Home

Detailed findings

Background to this inspection

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

This visit took place on 9 April 2015 and was carried out by an inspection team which was formed of three inspectors, an expert by experience and a specialist professional advisor. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. A specialist professional adviser is a professional who is qualified in the areas we are inspecting, in this instance, nursing provision. The visit was unannounced. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 16 people who lived at the service, 11 relatives and visitors, 16 members of staff, three deputy managers and liaised with the registered manager following the visit. We received feedback from health and social care professionals. We viewed 13 people's support plans. We were unable to view staff files as the deputy managers were not able to access them on the day of our visit. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Inadequate

Is the service safe?

Our findings

People did not always receive appropriate care that met their individual needs. This was in relation to personal care, continence care, wound care and support with their mobility.

We saw a nurse attend to a person who had fallen and sustained an injury. This person was in need of personal care as had suffered incontinence which increased the risk of infection to the wound. However, the wound was not cleaned, the nurse did not wear gloves or wash their hands and non-sterile dressing was used. In addition, personal care that was needed had not provided appropriately.

There were at least 40 people who were dependent on staff for all aspects of care, which included repositioning. These people were also assessed at high or very high risk of developing pressure ulcers. We noted that four of the five of the mattresses we viewed were not set to the correct setting for the person's weight. For example, where a person weighed 44.5kg the mattress was set to 80kg. Three mattresses were hard to touch and one person said, "It's uncomfortable." Although one person told us that they received regular repositioning "Even at night." We found people were not consistently repositioned at regular intervals. This was necessary to relieve the pressure on parts of the body most susceptible to developing a pressure ulcer. Staff told us that they did not usually involve a tissue viability nurse as some of the nurses working at the home had "…been on a tissue viability course." However, during the inspection we found that wound care was not always being managed safely and therefore affected the area that was required to heal. For example, wrong dressing types such as a plaster instead of a gauze based dressing, inconsistent treatment plans and practice that increased the risk of infection or development of a pressure ulcer, for example the incorrect cream and poor management of continence. We asked staff and five of the staff members caring for people who needed repositioning? were not able to name any people who needed regular repositioning. There were no records in use to clearly show when people had been repositioned and some staff were not able to tell us about people's individual needs therefore people could be placed at risk of not having their personal care needs met effectively or safely.

People needed various support and equipment to assist them to change position or to mobilise. However, risk assessments in relation to moving and handing were contradictory with the plans in place containing conflicting information. For example, the risk assessment for one person stated they were independent and another for the same person stated they required two staff and a handling aid. This meant that people were at risk of not receiving the appropriate and safe care. We observed people being assisted to stand and to move between their chair and wheelchair. We saw staff lifted people under their arms which is not a safe way of assisting people and can result in injury to the person being assisted and to the staff. We asked staff about safe moving and handling. One staff member said, "You need two carers to help the resident stand up from the chair under their arms." We brought our concerns to the deputy managers attention and they told us that they were not aware that moving and handling in the home was an issue but they would look into it as it was not a practice they approved of.

People were not receiving safe and appropriate care that met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there was not always enough staff. They said this meant they were waiting for long periods of time for assistance and that they regularly had to wait a long time for call bells to be answered. One person told us that they did not feel safe, they said, "There are no staff around." Another person said, "I had to wait up to three quarters of an hour for a bell to be answered." One relative told us, "Why do they have call bells if no-one answers them." We observed the call bell ringing for 20 minutes frequently throughout the inspection. We also observed people, and they told us, they had been waiting until 11am ro be assisted to get washed and dressed and others repeatedly calling out for assistance to get out of bed because staff were not available to help them.

Five people told us that they did not drink in case they needed to use the toilet. They said this was because they did not like to go to the toilet in their pads which they said staff had told them was easier than assisting them to the toilet. One person said, "It took me quite some time to get used to it but they say it's easier if I do it in my pad, that's why I don't drink because then I'll need [the toilet]." Two people told us they had to now wear continence products due to the waiting time to use the toilet. We asked the

Is the service safe?

deputy manager if this was common practice at the home and they told us it was not. However, further information seen confirmed that these concerns had previously been brought to the manager's attention.

There were 15 people who did not receive their breakfast until 10.30am as staff were unable to support them due to providing personal care to other people. On at least 10 occasions we had to prompt staff or locate staff when people were shouting out for assistance. Social care professionals told us that at times when they visited the home there were limited staff about, in particular at peak times, which included the evenings. One staff member was looking for a colleague to assist them told us, "I have been looking for a member of staff for ages and I can't find one." On the day of the inspection two staff members had called in sick which meant that staff had to be split across units to cover the shortfall. The deputy manager told us that they had not used agency staff in a long time and always tried to cover shifts with their own staff but this was not always possible. However, this meant that at times shifts were not covered leaving the home short staffed so that people did not always have their needs met.

There were not sufficient numbers of staff to make sure people's needs were met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were in excess of 20 people we saw who did not have access to call bells. They were either out of reach or in some cases, unplugged. We responded to a person calling out for help and found them on the floor in their bedroom. They told that they had been "Calling and calling" but did not know how long they had been there. The person was unable to use the call bell as it was unplugged and left in their arm chair. We saw people in the lounges without any means of calling for assistance. One person who was becoming anxious and trying to get up alone said, "I can't get to the toilet, I'm going to [soli] myself and no-one takes any notice". From the first time a staff member acknowledged the person it then took a further 20 minutes for them to assist the person to the toilet. We also saw a person in an unattended lounge for over 30 minutes without means of calling for assistance. In addition, their walking frame had been taken away from them and put behind some chairs out of sight and reach. When the person attempted to walk without their frame we had to summon assistance as they were at risk of falling. We asked the deputy about this who told us it may have been moved out the way of wheelchairs. However, we noted that the frame would not have been in the way if it had been left in the persons reach.

Staff did not carry out routine room checks of people who were in their bedrooms or lounge areas so there were extended periods of time where they may have been in need of assistance or at risk of falling without the means of calling for help. One person told us, "They should have someone come every so often and look but they don't, we sometimes don't see someone for hours, it's not right." Falls risk assessments stated that people needed regular checks and supervision, to ensure people had means of calling for help and their mobility aids should be easily accessible but in practice this did not consistently happen. We saw from records that the manager monitored falls monthly and the deputy manager told us that they had not identified any trends or particular concerns. However, this information had not been reviewed by the provider or independent person to ensure it was accurate.

Although staff told us that they were aware of the safeguarding posters in the home and told us that they would report any suspected abuse to the manager they were not clear on how to raise concerns outside of the home. Staff were also not clear about the local authority's role in relation to investigating safeguarding concerns. During our inspection we found a number of concerns that we reported to the safeguarding team which had not been identified and reported by the staff or manager.

Staff told us that one way to keep people safe was the use of bedrails. Most people were seen to have bed rails fitted to their beds. We saw that although the staff had carried out assessments, proper consideration to people's needs had not be taken into account. For example, where people were likely to attempt to climb over the rails there were no plans to minimise the risk of a person falling out of bed and sustaining an injury. We saw that three people were anxious and tried to climb over bedrails and others were lying awkwardly against them. We also saw that most of the rails did not have safety bumpers fitted, and four others that we saw the bumpers were fitted incorrectly. This increased the risk of entrapment. We asked the nurse on duty about this and they did not know that bumpers to reduce the risk of entrapment or injury and should be fitted to beds.

Inadequate

Is the service safe?

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. One person told us, "I often have my medication before I have my breakfast, that's not right." This was because they were meant to have their medicines with food. We observed people being supported to take their medicines and most staff worked in line with guidance. However, we saw one person who had difficulty swallowing and was on a pureed diet, was given their medicine in tablet form rather than in a liquid. We saw that this person started to cough and struggle to swallow these tablets. We saw that the nurse then gave them a spoonful of porridge to help them swallow their medicines. The management plan for this person was limited and staff told us they had not approached the GP to request a change to this person's medicine. This meant that person was at increased risk of choking due to receiving their medicines in a way that did not meet their needs.

Nurses had not received training since working at the home in the management of medicines. The nurses and the deputy manager told us that they did not have their competency assessed. The deputy manager told us that the nurses were about to undertake a self-assessment of their competency and if they assessed themselves as incompetent then training would be delivered. However, this meant that there were no formal supervisions or training to ensure that nurses were working in accordance with safe working practice to ensure people received their medicines safely.

We counted the amounts of tablets in stock for some boxed medicines. We found that eight of the 12 boxes counted contained the incorrect quantity which was recorded on the medication administration records (MAR). We spoke to the deputy manager who could not account for these discrepancies. We saw handwritten entries were not always countersigned in accordance with the homes policy and audits. We also saw that boxed and bottled medicines were not always dated when opened. This meant that the service could not ensure that people had received their medicines in accordance with the prescriber's instructions and therefore may have impacted on people's health.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Three relatives told us that they had concerns in relation to the skills and knowledge of some staff. They told us that there had been occasions when they had to insist on a specific type of care or medical input as staff had failed to identify this. One relative of a person recovering from an upper body injury explained how their relative had been assisted to move in a way which was not safe and would have caused pain. They told us, "I watched them lift [relative] under the arms, no equipment, they should have used a slide sheet."

Staff did not always have up to date training, skills and knowledge. We saw from records and the deputy manager told us that training was only delivered or updated if the management team felt it was needed. This included areas such as safeguarding people from abuse, risk management, MCA and DoLS, food hygiene, medicines and moving and handling. We observed that in all these areas there were gaps in staff knowledge which had impacted on people using the service. Training was being delivered in house to new staff members by a staff member who had not been appropriately qualified to deliver some of that training. For example, moving and handling training was being delivered by a trainer who had only received basic training themselves. The staff members who had received this training were supporting people with moving and handling and we observed this being down incorrectly. One to one supervision for staff had been implemented in the last two months. One staff member told us it was a, "new thing." However, the deputy manager and staff told us and records showed this supervision did not include assessing staff member's care practice or reviewing training needs.

We saw that on one unit which provided care to people living with dementia the nurse and senior care assistant took responsibility for directing staff in accordance with their roles as dementia champions. For example, the provision of stimulating activities and one to one supervision when needed. However, this did not happen throughout the home. Staff did not have their knowledge and competency assessed and reviewed. We were told by staff and the deputy managers that their 'hands on' practice was also not supervised so poor practice and training needs were not identified. This meant that people were receiving care and support by staff who did not have the appropriate knowledge and skills for their role.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the home or their relatives, where needed, had signed forms giving consent to the information held in care plans and for the care provided. Mental capacity assessments were carried out by the nurse if a person was identified as not being able to make their own decisions. A nominated person was identified to support the person with decision making. Although we observed people being asked by staff before care was provided, for example, "Can I put your apron on for lunch? It will help keep your clothes looking nice." We also observed instances when people's requests for assistance were not responded to.

Two of the senior staff members told us that DoLS had been applied for. One person said, "100% of everyone on this unit [dementia care unit] have a DoLS application because the doors are coded, we haven't had an outcome yet." They went on to say that they support people using the least restrictive option while waiting for feedback on the applications. For example, people had unlimited free access to the garden and if they want to go for a walk a staff member would accompany them. They went on to say that there had also been a referral for covert administration of medicines and were aware of other examples when a DoLS application should be made. For example, to provide personal care.

However, applications had not been made throughout the home in relation to other restrictive practice such as the use of bedrails. We noted that one person, who was attempting to climb over the bedrails, had it stated in their plan that the rails must be lowered to allow the person to get out of bed when they wish to. We observed this person calling out with their legs over the rails. We pressed the call bell and waited for 20 minutes for their call to be answered. The staff member came to the room, checked on the person and left without lowering the rails. We asked other staff members if they were aware of how the MCA and DoLS affected them in their role and staff were not able to tell us. Some staff told us it meant they had to ask people before assisting them, others did not know if anyone was subject to DoLS application. Some staff were not aware that practices we observed during our visit such as moving a person's walking aid out of their reach, depriving a person with means of calling for assistance and leaving bedrails in place when a person wants to get up could be seen as restraint.

Inadequate

Is the service effective?

The use of restrictive practices and restraint were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the food was good and that they had a choice. The menu was taken around the day before, except on the dementia care unit where visual choices were offered at the mealtime, when they have the opportunity to choose. We saw staff supporting people at the meal table and people were offered choices. We heard on staff member say, "Would you like custard and cake? Sometimes you prefer yoghurt, what would you like today? " We saw that people's weight was monitored and when they were assessed as being at risk of not eating sufficient amounts they were added to a chart that monitored their fluid and dietary intake. However, we saw that these charts were often not completed fully so did not provide an accurate picture of what people had eaten and drank.

We also found that three of the units breakfast was still being served at 10.30am and then lunch was served at 12.30pm which meant several people were not hungry between the time they received their breakfast and their lunch. One person told us, "Breakfast is always too late." And another person told us, "I'm not really hungry now." It was noticeable at lunch time observation that the majority of people who ate in the dining room left a part of their meal and some people refused dessert. The people who stayed in their rooms were served much later and we observed that at 2.15 pm in at least 10 of the rooms there were plates which had been left in there for sometime so the food was cold.

In the lifts there were notices telling people that snacks were available throughout the day and night and 'they only needed to ask'. However, people told us that they were not asked if they would like any fruit or snacks during the day. One relative told us, "I've never seen any snacks or fruit and I've never heard anyone being asked." We saw a fruit bowl had been left out in one of the lounges, but this was out of reach. We saw one person with limited mobility walk over to the bowl to eat some fruit. However as there were no chairs nearby, this person had to stand up to eat their fruit.

We saw that drinks were available but were frequently out of reach and we did not see people being encouraged to drink as staff passed through. We also saw a breakfast tray left for a person who had bedrails up which meant they were struggling to lean over the rails and stretch to get some food on their spoon. We brought this to the deputy manager's attention so they could support the person appropriately.

People did not receive the appropriate support to ensure they were able to eat and drink sufficient amounts to maintain their health and wellbeing. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the GP visits once a week and they can see them if they ask. One person told us "I get my name on the list and then I can see him." Two relatives told us that all their relative's health needs were being. However, three relatives told us that they needed to repeatedly ask and raise concerns about ill health before a GP was called. We saw that people had access to other healthcare professionals such as dieticians, chiropodists and the mental health team.

Inadequate

Is the service caring?

Our findings

People's privacy and dignity was not always promoted. When we arrived at 8am every bedroom door was open with people in varying degrees of undress. Some people we noted that their care plans stated that they wanted to bedroom door closed so that "People can't see in." However, this was not acknowledged and staff told us it was normal for the doors to be open unless personal care was being given. We also saw that one person who had been given assistance with continence care required further assistance. Their feet and carpet was soiled. Staff came into the room but did not assist the person with this therefore not treating them with dignity.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were living on the dementia care unit had good relationships with the staff. We saw them respond with affection and anxiety levels were kept to a minimum. We observed staff support people when they became worried and quickly defuse any situations that may escalate. For example, when two people were arguing over where to sit staff responded in a way that demonstrated a good understanding of the person's needs and preferences. This included involving them in conversation and an activity. We observed a range of caring qualities amongst the staff in the home. Many of them were kind and caring. For example, they would approach people gently, occasional touches on the arm or gentle guidance and encouragement. The activities co-ordinator was particularly skilful in supporting people who were anxious. They were calm, encouraging and positive in their approach. We heard them say to a person who as worried, "Come and sit with me and have a hand massage, you will enjoy that."

Although people on the other units told us that the staff were kind, caring we observed some examples of poor communication. This included staff not speaking to people or giving any explanations while providing support with moving and handling, not providing a clear explanation of care and one incident of staff speaking abruptly to a person who was anxious. We informed the deputy manager of this incident. We also observed that staff did not speak with people when assisting them, finishing a task with little or no interaction with the person.

We observed three occasions where staff did not know the name of the person who they were supporting and told us, "I'll have to go and check." This meant that they did not know about the person they were supporting or what their needs and preferences were.

We noted that the staff knowledge of residents was limited. We asked a staff member if they knew what a person was interested in so that perhaps they could engage in a different way but the staff member said, "Don't really know." One person told us, "They don't know anything about us." They went on to tell us about their family history and said, "No-one is really interested."

People told us that they could not remember being involved in the planning of their care. Two relatives told us that they were involved in the care plan. One told us, "I wrote the care plan for them." and the other told us, "I have seen the care plan but if I want anything for [relative] I just tell them." However another relative told us, "I've never seen a care plan or had [their] care discussed with me." They went on to say, "Do you mean like you sitting here with us now talking to us and finding out about us? No we've never had that – you are the first one." Following the inspection, the manager sent us a template of an individual preference form that they planned to implement to help involve people in the planning of their care.

Requires Improvement

Is the service responsive?

Our findings

People did not receive care that was responsive to their needs. This included support with personal care, the use of toilet facilities and support with mobility. People told us that staff did not always support them in a way in which they needed. Some people told us it was because staff were too busy. Relatives told us that they had observed practice that did not meet their relative's individual needs or changing needs. This included being clear on what support a person needed with mobility, eating and drinking and getting them up at a time that they preferred. One relative told us, "[Relative] needs to have mouthwash, [they] get Thrush, I have brought it in for [them] and told the carers [staff] every day but they never do it."

We saw that some care plans were individualised and gave clear guidance in relation to supporting a person with personal care and mobility. However, within the care plans, risk assessments contradicted themselves by stating that the person needed different care. The deputy manager told us that the manager had identified care plans as the next area in need of addressing. On the unit which provided care to people living with dementia, the nurse and senior care assistant were clear on what support people needed and described how they adapted care to meet someone's changing needs. For example, with equipment, one to one staff support or a referral to health professionals. However, other staff throughout the home were not able to tell us about people's specific needs and other staff had shown a lack of awareness of people's needs during the day of our inspection. For example, people needing support to eat, changing of a person's position or supporting a person who had been struggling with the transitional period of moving into a care home.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were three activities leaders in the home five days a week, on the day of the inspection two were working. We saw different activities going on in the dementia unit. This included crafts, music, people were having one to one reading in their bedrooms and doll therapy which was being thoroughly enjoyed by people. We saw that staff on this unit were in the process of creating a vintage style café and sweet shop for people to use. Staff told us this will also have tea making facilities for people and their relatives to use. We observed staff interact with people about the dolls and discuss parenting tips. One person introduced their baby [doll] to us and was totally engaged caring for the doll throughout the inspection. One relative told me that the "Activities lady is fantastic, she finds out all about them and then she does activities with them about the things that they like and enjoy."

However, on the other units we briefly observed some hand massage in the sensory room but of the 30 people on the unit only five were involved. Many people spent most of their day sitting in their own rooms with little interaction. Several people told us they did not join in with activities. One person said "I don't like doing any activities." A staff member told us that one of the people who spent all day in their room since their unit had moved downstairs although previously they had been very active and involved with the activities provided. The staff member said, "We can't force [them] to leave [their] room." However, they were unable to tell us ways that they may engage the person by using knowledge of hobbies and interests. One person told us, "I'm lonely, I am really lonely."

People observed in the lounges were not engaged in any meaningful activities, there were no members of staff available and very little interaction. None of the people we spoke with had any links outside of the home or access to the community. There was a 'Pat a dog' pet therapy poster in the lift but none of the people or their relatives that we spoke with had any experience of this in the home. People told us that there was a religious service at the home, however, staff were not able to tell us whether this was provided for all denominations.

Relatives told us that the manager held meetings twice a year. One relative told us, "They are done properly, a meeting first and then food and drink afterwards." However people were not aware of any residents meetings or other system in place to obtain the views of people who were living at the home. Following the inspection the manager sent us a questionnaire which has just been implemented to seek people's views and experiences.

People knew how to make a complaint if they needed to. One person told us that they had raised a complaint. However, they said only after a second occurrence of the incident was action taken and on the second occasion it was dealt with quickly and efficiently. One relative told us

Requires Improvement

Is the service responsive?

that they didn't complain, if there was a problem they went to the office and told them about it and it was sorted out. We looked at complaints log and saw the manager kept a log of complaints and action taken.

Inadequate

Is the service well-led?

Our findings

Leadership on the units was varied and there was no clear guidance or values displayed to let staff know what was expected of them. Staff were not aware of what the homes aims and objectives were or how they would be achieved. In the unit for people living with dementia the nurse and senior carer staff gave staff direction. However, we did not observe clear leadership on the other units throughout the inspection. This left units disorganised and people not receiving the support they needed and had a sizable impact on people's health and wellbeing. For example, limited support to eat and drink in acceptable timeframes, staff not answering of call bells and requests from people for assistance and staff, on two occasions, not knowing the name of the person they were supporting.

There were systems in place to monitor the cleanliness of the home, which had improved and been maintained since the last inspection. We saw that where issues had been identified, for example in relation to a cleanliness issue, this had been addressed. However, we also saw that audits carried out for care plans, medicines and checks around the home had not identified issues we found during the inspection. Therefore the systems in place were not always effective in identifying concerns or improving the service. In addition, there were limited systems to seek and use people's feedback.

We saw that when issues had arisen or complaints had been received, the manager had documented this in a meeting or in the staff monthly newsletter to raise awareness. However, we saw that the monitoring of these issues was limited and therefore did not minimise the risk of a reoccurrence and in some areas these issues had been on going without being resolved. For example, people raising concerns relating to people suffering dehydration and incomplete fluid intake recording charts, pressure relieving mattresses being on the incorrect settings and inappropriate personal care provision which had not been resolved. We also found that the provider did not carry out regular checks to ensure that the management team were carrying out their role to an acceptable standard. Information compiled by the manager was not reviewed or analysed to ensure the quality of the service provided or that legal requirements were met. In addition, the provider did not ensure that the service was being delivered in accordance with their statement of purpose. For example, to 'offer skilled care to enable people to achieve their optimum health and welfare.'

Staff told us that the manager had been providing guidance and the deputy managers were also available should they be needed. One staff member told us that things had really improved in the last three months and there were now three deputy managers who were in charge of routine audits including medicines, infection control and training. "They check nearly everything." However, the concerns that we found that were having a detrimental effect on people's care and well being had not been identified by the management team. For example, people not receiving care that met their needs, staff not receiving sufficient training and the lack of competency assessments of staff practice. We also found that with the exception of the cleanliness of the service, the audits were not identifying or resolving issues in other areas. For example, poor medicines management and care plans inconsistencies. Because these areas of concern were not being identified action was not being taken to address the concerns and make the necessary improvements to the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they knew the manager by name but did not have regular contact with them and usually spoke to one of the care staff if an issue arose. One person told us that following a recent bereavement the manager visited them every day. Relatives told us that they saw the manager in their office regularly and one relative said, "I tap on the office window as I go past and [they] always comes out to say hello." People told us that relatives and friends could visit any time. A staff member said, "It is open house here."

Staff told us that the manager's management style had 'improved' and this helped effective communication. One staff member said, "The manager is very supportive. I feel I could go to [them] with any issues, [they are] a good listener." Staff also told us staff meetings took place around every six months. Regular nurse meetings also took place.. Staff also told us that staff newsletters were distributed monthly to keep all staff up to date with events at the home in case they were unable to attend a meeting. We saw the staff newsletter for April and noted that it covered some of

Inadequate

Is the service well-led?

the areas we had identified as a concern at our inspection, for example, ensuring that people had enough to drink and accurately recording this. However, we found that although some of issues had been identified they had not been resolved and action taken to address the concerns was limited.

Health care professionals told us that they felt the service had improved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care **The care people received was not always appropriate and did not always meet their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **the service did not ensure people received safe care and do all that was reasonable to mitigate any risks to health and safety.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect.**

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 (RA) Regulations 2014 Meeting nutritional and hydration needs **people did not always receive the appropriate support to meet their nutritional and hydration needs.**

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 (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The management did not have effective systems in place to ensure the quality of the service was good.

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 (RA) Regulations 2014 Staffing There were insufficient numbers of staff to meet peoples individual needs.