Care Quality Commission

Newco Southport Limited

Fleetwood Hall

Inspection report

100 Fleetwood Road,
Southport, Merseyside,
PR9 9QN
Tel: 01704 544242
Website:

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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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection of Fleetwood Hall care home took place on 6 and 7 January 2015.

Fleetwood Hall is a large care home set in its own grounds on the outskirts of Southport. The home is registered to provide accommodation for up to 53 people across four units. At the time of the inspection 36 people were living at the home. The units include:

- Female unit that can accommodate 14 women with mental health needs
- Andrew Mason Unit - a male unit that can accommodate 14 men with mental health needs
- Dementia care unit that can accommodate six people
- A general nursing unit for up to 14 people.

A registered manager was not 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 2008 and associated Regulations about how the service is run.

People living at the home were not protected from abuse. We observed behaviour that was abusive and people living there told us staff were belittling towards them. We

Summary of findings

heard staff speak to people in an unkind and derogatory way on the Andrew Mason Unit (AMU). You can see what action we told the provider to take at the back of the full version of this report.

We found the staffing levels on the dementia care unit were inadequate to ensure people's safety was maintained at all times. For example, we observed that there were periods of time when just one member of staff was on the unit. You can see what action we told the provider to take at the back of the full version of this report.

Effective staff recruitment processes were in place.

Individual risk was not well managed on the AMU and dementia care unit. We observed a person who was funded for one-to-one staff support unaccompanied by staff for periods throughout the day. Individual risk assessments and risk management plans were either not in place or were poorly completed. You can see what action we told the provider to take at the back of the full version of this report.

Care plans were not in place for people prescribed PRN medication (medication taken when it is needed) on the dementia care unit and AMU. A person was receiving covert medication (medication hidden in food or drink) on the AMU but this had not been agreed through a best interest discussion with the person's doctor. A care plan was not in place to outline how the covert medication should be given. You can see what action we told the provider to take at the back of the full version of this report.

We found that areas of the home were unclean and unhygienic, particularly the AMU and dementia care unit. For example, the sink, work surfaces, cupboards and fridge in the rehabilitation kitchen on the Andrew Mason Unit (AMU) were dirty. You can see what action we told the provider to take at the back of the full version of this report.

We had concerns about the condition of the building. For example, toilet paper was used to plug gaps in some window frames to prevent draughts. A ligature risk assessment had not taken place and we observed potential ligature points on the AMU. You can see what action we told the provider to take at the back of the full version of this report.

Care records on the AMU and dementia care unit contained minimal information about people's health care needs. Care plans had not been developed for specific health needs or conditions people had been diagnosed with. You can see what action we told the provider to take at the back of the full version of this report.

Staff training and staff supervision was not up-to-date. You can see what action we told the provider to take at the back of the full version of this report.

People told us the food was good and they got a choice at each mealtime.

Practices were in place that people living there had not provided their consent to. For example, some people's cigarettes were kept by staff and given out at smoke breaks. People did not manage their own money and it was held in the unit safe. The Mental Capacity Act (2005) had not been taken into account in relation to people making decisions about their care and restrictive practices. This was particularly evident on the dementia care unit. The environment on this unit was very restrictive as the bathrooms, kitchen/dining room, bedrooms and people's wardrobes were locked. You can see what action we told the provider to take at the back of the full version of this report.

The design and layout of the dementia care unit was not suitable to the needs of the people living there. Reasonable adjustment's had not been made on the AMU for a person who was a wheelchair user. You can see what action we told the provider to take at the back of the full version of this report.

Staff on the general nursing unit and female unit were kind and caring towards the people living there. We did not find this level of kindness and compassion on the AMU and dementia care unit. On these units we observed very little meaningful interaction between the staff and the people living there. Staff on the dementia care unit were not familiar with the personal histories of some of the people living there. There was no evidence that people or their representative on the AMU and dementia care unit had any involvement in developing or reviewing their care plans. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

Care was not person-centred on the AMU and dementia care unit. Care records contained minimal information about people's personal history or current preferences and aspirations. Preferred routines were not recorded for people on the dementia care unit. Some people on the dementia care unit had limited verbal communication and communication plans were not in place. You can see what action we told the provider to take at the back of the full version of this report.

We observed no recreational or social activities taking place on the AMU and dementia care unit. There was no evidence in the care records of meaningful activities taking place on a regular basis. People living on the AMU told us there was very little to do. You can see what action we told the provider to take at the back of the full version of this report.

A complaints procedure was in place and the manager provided details of a recent complaint that had been resolved to the satisfaction of the complainant.

The manager of the home had been supporting the previous manager since October 2014. They had started working there full time the day before our inspection. The manager was aware of many of the concerns we found with the service and had started to address these. For example, performance management procedures and disciplinary processes were being used to address staffing issues.

The new manager had changed the management structure and unit managers had been appointed. This meant the unit managers were responsible for the day-to-day management and leadership of their respective units. The majority of staff and people living at the home were positive about the new management changes.

Structures to monitor the quality and safety of the service had been introduced recently. These included audits, analysis of incidents, staff meetings and meetings for people living in the home. An activities coordinator had been appointed shortly before our inspection.

The new manager and the changes being made would suggest the service was in the early stages of actively addressing some of the concerns we found. However, it was too early to see the impact these changes were having in 'turning the service around'.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Best practice procedures had not been followed for administering PRN and covert medication.

Staffing levels were inadequate to ensure the safety of the people living at the home.

People were not safeguarded from abuse.

Behaviour that challenges was not always managed appropriately.

Effective arrangements were in place for the recruitment of staff.

Some areas of environment were not safe, well maintained or clean.

Is the service effective?

Inadequate

The service was not effective.

Health assessments and health care plans were not in place for some people with specific health needs.

Staff training was not up-to-date.

People were satisfied with the food and received a choice at each meal time.

Staff were not adhering to the principles of the Mental Capacity Act (2005).

Reasonable adjustments had not been made to the environment for a person who was a wheelchair user.

Is the service caring?

Inadequate

The service was not caring.

Some staff were not caring and kind in the way they treated people. People were not treated with dignity and respect by all staff.

Some staff were unaware of people's personal histories and background.

People and/or their families were not always involved in the development and review of their care plans.

Is the service responsive?

Inadequate

The service was not responsive.

Many of the care records contained either no or limited information about people's relationships, working life, hobbies, interests and preferred routines to support staff with getting to know each person.

There were very limited social and recreational activities for people living at the home.

A complaints procedure was in place.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

A new manager had started at the home and was applying to be the registered manager.

The manager acknowledged that there were shortcomings with the service and had already started to make changes. However, it was too early to see the impact these changes were having in 'turning the service around'.

The changes included the appointment of unit managers, addressing staffing issues, updating the environment and auditing the service.

People living at the home and most of staff were positive about the changes and the future of the home.

Fleetwood Hall

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 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This unannounced inspection was undertaken by one inspector on 6 and 7 of January 2015. The inspection team consisted of an adult social care inspector, a specialist advisor in adult mental health, an expert by experience with expertise in mental health and an expert by experience with expertise in older adult health care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We had asked the provider (owner) to submit a Provider Information Return (PIR) prior to the inspection but we did not receive this. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before our inspection we reviewed the information we held about the home. We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service and local mental health service to obtain their views.

During the inspection we spent time with 15 people who lived across the four units and spoke with two family members who were visiting at the time of the inspection. We spoke with the operational manager, manager of the home, three unit managers, the chef and 13 nursing and care staff. We sought the views of a GP and a healthcare professional who were visiting the home at the time of our inspection.

We looked at the care records for 10 people across the four units, four staff recruitment files and records relevant to the quality monitoring of the service. We looked round the home, including some people's bedrooms, bathrooms, dining rooms and lounge areas. We carried out a Short Observational Framework for Inspection (SOFI) on the dementia care unit. SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

Inadequate

Is the service safe?

Our findings

People living at Fleetwood Hall were not protected from abuse. Some of the people who lived on the Andrew Mason Unit (AMU) told us staff were belittling towards them. One person said, "The staff talk down to me. [Named staff member] calls me by wagging their finger [at me]." Another person said, "I was told [by a member of staff] I was a waste of taxpayer's money."

During the inspection we overheard a member of staff on the AMU say to a person who was trying to express a worry about their health, "Sit down and shut up."

On the AMU we witnessed an incident. We informed the manager who immediately took action to ensure the safety of the people on the unit. The incident is currently being investigated both internally by the provider and also by external agencies.

A person on the general nursing unit approached us to make a complaint about a member of staff. The person said the member of staff had recently inappropriately restrained them and told them they were, "An attention seeker and were not wanted on the unit." We informed the manager who immediately took action, ensuring the person and others living there were safe from any further contact with the member of staff.

A person told us that a member of staff on the AMU only gave small portions of food to people and then had a "huge plateful" of the remaining food even though people had not got enough to eat. Although the chef told us bread was available at mealtimes, the person said the member of staff refused to give people bread on the unit. The manager was aware of this issue and was addressing it.

Three people living on the AMU told us they were frightened of another person living there. One person said, "He shouts and screams at us and I accidentally hit him over Christmas. When staff are with him he is less likely to pick on us." The person the people referred to was funded for one-to-one staff support from 8.00am to 8.00pm. We could not find a risk assessment or care plan in the person's care record outlining why he was on one-to-one support. There were periods throughout the inspection when we observed the person walking around the unit unaccompanied by their one-to-one member of staff. We asked the unit manager about this who advised us the staff had been reminded that the person should have one-to-one staff support at all times.

An adult safeguarding policy was in place. Training monitoring records informed us that 27% of the staff team required adult safeguarding training.

By not making suitable arrangements to ensure people were safeguarded against the risk of abuse was a breach of Regulation 11(1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

To determine how individual risk was managed we looked at the care records for all five people who lived on the dementia care unit. Staff told us most of the people could present with behaviour that challenges. Each of the care files lacked information in terms of providing a detailed risk assessment and comprehensive risk management plan. For example, staff said one of the people had been challenging in a public place yet we found no risk assessment or care plan to guide staff with how to manage these types of incidents in the future.

We looked also at the incident reports related to the dementia care unit for September, October and November 2014. We could see that most of the incidents involved one person who displayed unpredictable and frequent assaultive behaviour towards staff and others living there. The person's care plan made reference to assaults on staff but made no reference to assaults on the other people living on the unit. The first two actions on the care plan were for the person to be reviewed by the psychiatrist and to ensure the person was offered PRN medication. PRN medication is medication that a person takes when they need it. There was no reference to the use of distraction or engaging the person in an activity to minimise the level of challenging behaviour. Staff confirmed that not all of the incidents between people living on the unit had been reported as an adult safeguarding concern.

In addition, we looked at three care files on the AMU. Although people had known risks, risk assessments and associated risk management plans were either not in the care records at all or were poorly completed. For example, one person could only access the community with two members of staff. Staff told us this was because the person had a history of substance misuse and self-harm. However, there was no risk assessment or care plan in place

regarding these risks and how they should be managed. We noted from another care record that the person had a history of engaging in an illegal activity, which could present a serious risk to certain population groups. There was no risk assessment or management plan to indicate how the risks should be managed both in the home and in the community.

Training monitoring records informed us that 29% of the staff team required training in challenging behaviour.

By not taking proper steps to ensure people were protected against the risks of receiving unsafe care was a breach of Regulation 9(1) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we inspected the home in July 2014 we identified there was insufficient staff at all times to ensure people's safety. This was a breach of regulation and we made a compliance action. On this occasion there were mixed views amongst staff regarding the staffing levels. Staff who worked on the general nursing unit, AMU and female unit said the staff levels had improved and there were now sufficient numbers of staff at all times. However, staff on the dementia care unit said they sometimes did not have enough staff. We observed periods of time on the dementia care unit when there was only one staff available. Staff confirmed that there was usually two staff with registered nurse support from the AMU. They said the staffing level reduced to one when staff went for their breaks. Given that some of the people present with unpredictable behaviour that challenges, this staffing level was inadequate to ensure people's safety.

Due to risks in the community one of the people on the AMU could only access the community with the support of two staff. Staff told us that the mini bus driver was being used as the second member of staff due to a shortage of staff. We checked the training records and they informed us that the driver had not completed training in adult safeguarding and challenging behaviour.

Not having sufficient numbers of suitably qualified staff at all times was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A process for undertaking a dependency assessment was in place. Dependency assessments are often used as a guide when deciding on staffing levels. Most of the care files we looked at on the dementia care unit and AMU contained blank dependency assessment forms. Some had been completed on the dementia care unit but had been done so incorrectly, which gave an inaccurate measure of a person's dependency.

We looked at the personnel records for four recently recruited members of staff. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff.

People on the general nursing unit told us they received their medication at a time when they needed it. We observed that medication was administered safely on the general nursing unit. We also looked at how medicines were managed on the AMU and dementia care unit. Medication was held in a secure trolley in a dedicated room. The room was locked when not in use. We observed a nurse giving people their medication safely on the AMU. The medication administration records (MAR) were appropriately completed after the medication was administered to each person. Some people had PRN medication on the AMU and dementia care unit but we were unable to locate a care plan which outlined how and when PRN should be given.

A person on the AMU received their medication covertly. This means medication is disguised in food or drink so the person is not aware they are receiving medication. Staff told us this approach was taken as the person did not like taking medication. There was no record in place to indicate whether the person had mental capacity to make decisions about medication. Equally, we could not see that a doctor had been involved in the decision making regarding medication being administered covertly. A care plan had not been developed to describe how staff should administer the medication in food and what they should do if the person did not wish to eat the food or drink which contained the medication.

By not following good practice guidance regarding the use of PRN and covert medication was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed that some areas of the home were very unclean. This was particularly evident on the AMU. One of the people living there said to us, "I don't use the other bathroom because it is always dirty with s*** from the staff changing a resident." We observed the walls, ceilings and

Inadequate

Is the service safe?

floors of the dining room were dirty with splashes of a substance which we thought might be bodily fluids and the remains of food. Crockery and dining tables were not very clean even when they had been washed. There were disposable urine bottles lying about and we observed jugs of dirty shaving water with razors left in a room. The leaflet holder contained crumbs and used tissues. We observed that the sink, work surfaces, cupboards and fridge in the rehabilitation kitchen for people living on the unit to use was extremely dirty. The carpet on the stairs was heavily stained.

The dementia care unit had a strong smell of urine. The inside of the fridge was dirty yet we noted the cleaning schedule indicated it had been cleaned the day previous. The female unit and the general nursing unit were cleaner than the other two units.

A number of staff we asked were unable to tell us if there was a sluice room in the home. The manager confirmed there were a few sluice rooms. They told us used urine bottles were disposed of in yellow clinical waste bags. We looked at the laundry area and noted it was disorganised. There were separate areas for dirty and clean laundry but these were not used effectively and we saw clean laundry alongside red bags of soiled laundry.

The manager informed us that the lead nurse for infection control had recently left the service and an alternative lead had not yet been identified. Training monitoring records informed us that 78% of the staff team required infection prevention and control training.

Not maintaining appropriate standards of cleanliness and hygiene was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although there was recorded evidence in place indicating the premises was checked to ensure it was safe, we had concerns with the environment particularly on the AMU. The building is old and it appeared to us that remedial work was needed. For example, we observed window ledges were coming away from windows and tissue paper was used to plug gaps in the window frames to prevent draughts. Radiator covers had been put in place but not secured to the wall. There was no nurse-call system in place and a person who was physically dependent on staff said he had to shout for staff if he needed help. The person said sometimes nobody came and another person living on the unit helped him.

Some of the people on the AMU had a history of self-harm therefore we checked the unit for ligature points. We could see that there were potential ligature points, such as an old fire hose reel behind a door and handles on walls. A ligature point risk assessment had not taken place on the AMU or throughout the building.

We noted that the majority of people living at the home had a personal emergency evacuation plan (often referred to as a PEEP) in place. The manager confirmed the home had recently been subject to a full fire inspection and no significant concerns were raised. Training monitoring records informed us that 20% of the staff required fire safety training.

We noticed a strong small of cigarette smoke coming from one of the bedrooms on the AMU. The person whose bedroom it was said he smoked a lot in his room. We did not see any risk assessments or management plans in the care files for people who smoked.

By not protecting people against the risks associated with the environment was a breach of Regulation 15 (1) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

We spoke with two family members who were visiting their relatives on the dementia care unit. Both told us their relative's health care needs were being met and staff arranged for their relative to see the doctor or other healthcare professional if needed.

We spoke with two health care professionals who were visiting at the time of our inspection. One of the professionals was satisfied that staff responded promptly to people's changing physical health care needs. The other professional visited the service on a regular basis and had concerns about conflicting communication from staff. For example, the professional had found that what staff were reporting was not always reflected in the care records.

People on the general nursing unit told us the nurses responded well to any health care needs they had and would call a doctor if needed. We looked at the care records for a person on the unit. It was well completed in terms of the person's health care needs and how staff should respond if they were concerned about a person's health.

We looked at the care records for all five people on the dementia care unit. There was minimal information recorded about people's health care needs. Detailed health need assessments were not in place. We established from talking with staff that people on the unit had specific health care needs and we did not always see care plans to outline how these needs should be met. For example, one person experienced seizures and last had a seizure four weeks prior to the inspection. There was no risk assessment or care plan in place to indicate how staff should respond when the person had a seizure.

We looked at the care records for three people on the AMU and there were no health assessments or health plans in place despite people having specific health care needs. For example, one person had a heart condition. We could not see from the records whether people had access to health services, such as a dentist or chiropodist. We heard a person on the AMU telling staff on numerous occasions that his stomach was hurting and that he would like to see a doctor. We noted that staff ignored his requests and the person became agitated. We asked a member of staff why they were not responding to the person's request. They said, "He's new here, we don't know him." We informed the unit manager about what had happened and she arranged for the person's GP to visit him.

By not undertaking a detailed assessment of each person's health needs and planning how to meet those needs was a breach of Regulation 9(1) (a) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff we spoke with said they had recently received an annual appraisal from the previous manager and the current manager confirmed this. However, the manager told us staff supervision was not up-to-date. We looked at the training monitoring record and not all staff were up-to-date with the training the provider required them to complete. For example, 87% of the staff required training in dementia care and 49% required training in mental capacity. There were two people on the dementia care unit and a person on the AMU who had specific health conditions and/or needs and staff had not received training in these areas.

Not providing staff with appropriate training and supervision was a breach of Regulation 23(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People living on the general nursing unit said the food was good and they got a choice at meal times. One person said they would like more to drink during the day. We noted that people were frequently offered drinks throughout the day and were provided with extra drinks if they requested them. We observed the lunch time meal and there was a choice of meal. The food appeared appetising and was well presented, including blended meals. People told us the chef would make them something else if they did not like the choices available. There was plenty of staff at lunchtime to support people who needed assistance with their meal. This support was provided by staff in a warm and engaging way making the lunchtime a pleasurable experience. We observed lunch being served on the AMU. There was a choice of meal and people who needed help received it.

We spoke with the chef who had a full understanding of people's dietary needs. From our discussions with the chef and kitchen staff we found them to be highly motivated

with a desire to provide the best possible service. The kitchen was awarded '5 stars' (highest rating) by Sefton Council in November 2014 for cleanliness and food storage preparation.

We looked at how people provided consent to their support and care, including how the home worked within the legal framework of the Mental Capacity Act (2005). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances.

Forms were in the care records for people to sign to say they gave their consent to matters, such as consent to care and their photograph being taken. We looked at a person's care record on the general nursing unit and the consent forms had been appropriately completed by a family representative. None of the consent forms on the AMU and dementia care unit that we looked at had been completed or signed by the person or their representative.

A mental capacity assessment form had been developed for the home but it failed to include the crucial five questions for assessing a person's mental capacity regarding a specific decision they needed to make. We highlighted to this to manager at the time of the inspection who immediately sourced an alternative form. Although the majority of the care records we looked contained mental capacity assessment forms, they were either blank or at best partially completed.

People on the female unit and some people on the AMU did not look after their own cigarettes. Staff kept the cigarettes and handed them out at smoke breaks. People told us they had not agreed to this arrangement and there was no information, such as a mental capacity assessment or risk assessment in the care plans to indicate why people were not able to manage their own cigarettes.

In addition, people did not manage their own personal money. Staff told us the money was held in the unit safe because there were no lockable facilities in people's bedrooms. Again there was no information in the care records to indicate that people had consented to their money being held in the unit safe. A member of staff said to us, "Residents have to ask for money. We always ask why [they want it] and sometimes don't give it."

We noticed that there were some locked rooms on the AMU which meant people on the unit were restricted from using these areas. For example, the dining room was locked when not in use. We were told staff kept their food in a fridge in the dining room and it was locked to stop people living on the unit eating their food. This meant people were being restricted from accessing the rooms in their home because of staff needs.

We spent a large amount of time on the dementia care unit and could clearly see that people may not have the mental capacity to make many decisions about their care. Family members we spoke with said they had not been involved in decision making about specific care decisions their relative would be unable to make. The care records contained no information to suggest that mental capacity assessments had been completed and best interest meetings or discussions had taken place about various elements of people's care.

We found the environment on the dementia care unit was very restrictive. The exit/entry door was locked, all the bedroom doors were locked, the bathroom/toilets and the kitchen/dining room was locked. People's wardrobes were also locked. We asked staff why so many rooms were locked and the answers we were given were not related to risk. For example, we were told, "This is what has always been done" and "They [people] might mess their rooms up." Regarding the locked wardrobes, a member of staff said they were kept locked to prevent people pulling clothes and other items out. There were no risk assessments or best interest decisions in the care records to suggest a need for these areas to be locked. A family member told us they had not needed to lock rooms in their house prior to their relative's recent move to Fleetwood Hall.

Given the level of restriction on the dementia care unit, we were surprised that none of the people living there was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We discussed this with the manager who said they would prioritise making DoLS applications for all the people on the unit.

Two of the people on the AMU were subject to a DoLS standard authorisation. We asked to see the DoLS plan for each person. Staff could not locate the paperwork for one person but contacted social services and a copy was forwarded to the home. The unit manager was new but was

Is the service effective?

unaware there was a second person on the unit subject to a DoLS authorisation. The second DoLS stated, "A restraint policy is in place – physical restraint to be used as last resort". This was confusing as the manager and staff told us the home had a no-restraint policy and staff were just trained in 'safe holds'. We were informed that none of the staff had received training in 'safe holds' and breakaway techniques for two years.

By not obtaining valid consent to care and adhering to the principles of the Mental Capacity Act (2005) was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked to see how people's needs were being met by the adaption and design of the environment. The dementia care unit was not suitable for the people living there. We observed that two people liked to walk about almost continuously. The unit was small and because people were restricted from using many areas of the unit this left a small lounge and a short narrow corridor for people to walk about in. There was only one lounge and we noted the television was constantly on, which meant people had no alternative or quiet space to use. There was no dedicated space for activities. There was access to a small garden area but this was locked the whole time during our inspection. The lounge was bright, colourful and pleasantly decorated but the corridor and most of the bedrooms lacked a homely feel and any personalisation. Colour contrasting and clear signage on doors had not been used to promote independence. People's names or a photograph were not on their bedroom doors to assist them in locating their rooms. Due to its small size, staff said they thought the environment was unsuitable for people with behaviour that challenges.

Three rooms on the AMU had been personalised to each person's preference. People had their own furniture and television. One of the people on the unit had physical and mobility needs that required environmental adjustment's to support the person's independence and safety. These adjustments had not been made based on the person's needs. There was no disabled toilet on the unit but the person could use one on the ground floor if they wished. The person told us their wheelchair could not fit through the bathroom door on the unit which meant they were reliant on staff for assistance to transfer to a shower chair outside of the bathroom in order to use the shower. We observed that adjustments had not been made to the person's bedroom. The AMU had no call bell system and the person told us they had to shout to staff for assistance.

By not ensuring the environment was suitable to the needs of the people living in the home was a breach of Regulation 15(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service caring?

Our findings

On the general nursing unit and the female unit we observed that staff were caring in the way they communicated with people. The interaction between them was warm and friendly. We observed staff chatting with people as they passed by and asking how they were. People on the unit told us staff respected their privacy by knocking on their bedroom doors before entering and they said they were supported with personal care in private. One of the people told us, "The staff here are fine." Another person said, "I like it here and my room is lovely."

In contrast, we did not find staff caring or compassionate on the AMU. Many of the staff were neither warm or friendly when they interacted with people. One of the people on the unit said to us, "I don't like the staff. I try to tell them but they don't listen to me." Staff were dismissive of people. For example, we overheard a member of staff say to a person who was asking a question, "I don't want to know." This was said to the person three times; each time the member of staff raised their voice more. Another person became anxious and distressed about something and we heard a member of staff say to him, "Okay [person's name] that's enough." Some of the people on the AMU looked unkempt and we observed two people walking around in dirty clothes.

Equally, on the dementia care unit there was limited meaningful staff interaction with the people who lived there. We were talking to a member of staff when a person who lived there asked a question and the staff member said "shush" and ignored the person's question. The person quickly afterwards started to display challenging behaviour. This meant staff had not responded to the person in accordance with their care plan which stated, "Allow [person] to fully express their needs and give time and empathy."

We asked staff about the personal history of the two people on the dementia care unit, such as what career the people had and their hobbies. Staff were unsure and confirmed they did not know much about the people. A member of staff said it would be helpful if staff were provided with information about a person before they were admitted to the unit.

We spoke with a family member on the dementia care unit and asked them how well staff interacted with the people there. They said, "Staff come in sit down read the paper or watch television."

People on the general nursing unit and/or a family representative had some involvement with developing and reviewing their care plans. Equally, people on the female unit said they were involved in planning their care and support. We found no evidence in the care files at all that people on the AMU were involved in deciding on and reviewing their care. All the people we asked said they did not know what a care plan was. They had no recall of staff discussing or planning their care with them.

Two family members who were visiting their relatives on the dementia care unit told us they had not been approached by staff to discuss their relative's care plan. We looked at all the care files on the unit and there was no evidence of family involvement.

By not treating people with compassion, dignity and respect, and involving people in decisions related to their care was a breach of Regulation 17(1) (a) (b) (2) (c) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Our findings

The care files we looked at on the AMU and the dementia care unit contained either no information or very limited information about people's personal histories. A 'This is your life' booklet was in each file but they were blank or at best poorly completed. This meant there was no information about the person's relationships, working life, hobbies, aspirations and preferences in order to plan activities or for staff unfamiliar with the person to get to know the person. Care plans were in place but they contained limited information. Information about people's preferred routines was not in place for people on the dementia care unit. This type of information is important for staff, especially new staff, as some of the people on the unit were unable to verbally express their needs in a coherent way. Furthermore, we could not see that communication plans had not been developed for people with complex communication needs.

By not taking proper steps to ensure people's individual needs were met was a breach of Regulation 9(1) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Person-centred care was more evident on the female unit and the general nursing unit. A person on the female unit told us staff were supporting her to pursue educational opportunities. People on the general nursing unit told us they enjoyed regular activities, including trips out in the mini bus. One person told us of a trip to an Italian restaurant and said they were looking forward to going to ten-pin bowling. We looked at care records on each of these units. In the main, they were person-centred and reflected people's individualised needs and preferences.

Throughout the inspection we observed no recreational activities taking place on the dementia care unit. Two people spent a lot of time walking up and down the corridor, sometimes accompanied by staff. Others sat in the lounge. Although the television was on, they did not appear to be watching it. Some people had boxes containing toy bricks and tools. We did not see people using these. There was minimal meaningful engagement between the staff and the people living there. A family member told us they had never seen any activities taking place on the unit. Staff told us there were rarely trips out because some people could be challenging in the community.

On the AMU we observed very little meaningful interaction between the staff and the people living there. Most people spent a lot of time walking up and down the long corridor. Others were sat for hours in a quiet lounge. Some people had care plans outlining the activities they liked to engage with. For example, one person's activity plan indicated they liked swimming, visiting the library, sitting in the garden and walks. From what we observed and read in the care records there was no evidence that these activities had been happening. One of the people living there told us, "I am paid to do the garden and to brush up outside but there's nothing to do otherwise." Another person said to us he was on the unit for rehabilitation to prepare him to go home but has had no physiotherapy and no help from staff.

An activities coordinator had started working at the home three weeks prior to our inspection. It was too early to see if this new role was having a positive impact. The activities coordinator was working 30 hours a week and we considered this was an insufficient amount of time to cover all four units supporting people with very diverse needs. We discussed this with the manager who said they had further options to increase recreational and social support opportunities for people.

By not providing people with appropriate opportunities and support to promote their independence and community involvement was a breach of Regulation 17(i) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A complaints procedure was in place. We discussed with the manager a recent complaint the home had received and it had been managed effectively and to the satisfaction of the complainant. People we spoke with on the nursing said they would tell the manager if they were concerned about anything.

A 'resident's meeting' so people could express their views was taking place on the AMU on the first day of our inspection. Staff told us these had not taken place for a long time but the new manager had started them and this was the first one.

We could see that feedback questionnaires about the service had been completed. They were not dated and nobody was able to tell what timeframe or year they related to. They had not been analysed. The manager told us she planned to undertake a further survey to ensure it was current.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in post as they had left the service in September 2013. A new manager had been appointed and had applied to register as manager with the Care Quality Commission (CQC). They left the service shortly before our inspection and before their registration was processed. At the time of our inspection the registered manager from one of the provider's other registered care homes had been managing Fleetwood Hall. They had provided support one to two days a week to the previous manager from mid-October 2014 and had started managing the service full time the day before our inspection. They were in the process of submitting an application to CQC to register as manager of the service full time.

A provider information return (PIR) had not been submitted. The operations manager said they had not received a request for a PIR. We checked our system and noted the contact details for the home related to the previous registered manager. We highlighted to the manager that it is the responsibility of the provider to ensure that CQC has the most up-to-date details for the service.

The new manager of the home was aware of many of the concerning issues we raised throughout the inspection. The manager had started to address these, including the concerns with institutional practices we had found. For example, performance management procedures and disciplinary processes were being used to address a number of staff issues in relation to attitude and conduct. New staff had been recruited and recruitment was on-going. A review of skill mix was being undertaken. Staff training had been organised to take place throughout January and February 2015, including training in dementia care, infection control and first aid. The manager was looking into providing person-centred training for all the staff. Updating the environment had started as decorators had been contacted and new carpets were due to be fitted on the stairs and in the lounge of the general nursing unit. The manager advised us she was working on reviewing the management of people's personal money so they managed it themselves where possible.

Previous managers were responsible for the overall day-to-day management of the units. This had recently changed and unit managers had been employed to manage and provide leadership on each of the units. Three unit managers had taken up post shortly before our inspection. The manager was still recruiting for a unit manager for the dementia care unit. The unit managers were registered nurses. We could see that changes had started to happen since the unit managers took up post, mainly on the general nursing unit and female unit as these two unit managers had been in post the longest.

We asked people living at the home how they felt about the changes being made. People were positive about this. With reference to the new manager on the AMU one person said, "More has happened in the short time she has been there than in all the time I've been here."

We spoke with the unit managers. They were aware of the concerning issues, particularly communication and attitude issues between staff and people living at the home. They were motivated to make positive change and were fully aware of the challenge they faced. One manager said to us, "I was sent to Coventry at first because of the changes but since then things have improved and staff have apologised for their behaviour."

There were mixed views amongst staff about the changes. Some staff said they had not seen any improvements and said the morale was low. A member of staff said to us, "I don't like all this change. I've been here 12 years and I know what to do. I carry out the routine. Why does it have to change?"

Other staff were more positive about the future of the service. With reference to the new home manager a member of staff said, "She is doing a good job and having to catch up on things that have not been done like audits." A member of staff also told us, "We did not feel we had support or direction. It is better now but will take time. There is light at the end of the tunnel."

We asked some staff about whistle blowing. They were aware of what whistle blowing meant and said a policy was in place at the home. Some staff said they would be hesitant to whistle blow in case they were not supported by management. Others said they would feel comfortable raising concerns with the manager.

The manager informed us and staff confirmed that staff meetings had started. The manager attended these meetings. Meetings were starting for people living at the home and the first one was held on the AMU during the

Inadequate

Is the service well-led?

inspection. We attended the meeting. The changes and expectations of the staff were discussed. We noted that staff and people living on the unit were positive about the plans being put in place for things to change.

The manager informed us that audits and checks had started. They included a medication audit, a domestic audit, kitchen audit and infection control audit. We could see from the compliance percentage scores that issues were being identified. For example, the medication audit had a compliance score of between 53% and 59% for each unit. Action plans had been developed if required following the audits. The manager and unit managers were aware of the concerns with the care records, particularly on the AMU and dementia care unit. A selection of care records were audited in December 2014. Some of these scored very low in terms of compliance and we noted an action had been set that required an urgent review of the care records with the lowest compliance score. The manager had a process in place to review and analysis incidents on a regular basis.

The new manager and the changes being made would suggest the service was in the early stages of actively addressing some of the concerns we found However, it was too early to see the impact these changes were having in 'turning the service around'. Equally, it was too early to see if the new leadership of the service was driving through the actions required to deal with the breaches of regulations that we found.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People living at the home were not safeguarded against the risk of abuse. Regulation 11(1)(a)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People living at the home were not protected against the risks of receiving unsafe care. Regulation 9(1)(b)(ii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People living at the home were not supported by sufficient numbers of suitably qualified staff at all times. Regulation 22.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People living at the home were at risk from not receiving their medicines in a safe way because published guidance about how to give medicines safely was not being followed.Regulation 13.**

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 Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Appropriate standards of cleanliness and hygiene were not maintained at the home. Regulation 12.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People living at the home were not protected against the risks associated with unsafe or unsuitable premises. Regulation 15 (1)(c)(i).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **An assessment of health needs and a care plan indicating how to meet those needs should be met was not in place for all the people living at the home. Regulation 9(1)(a)(b)(i).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff training and supervision was not up-to-date. Regulation 23(1)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Suitable arrangements were not in place for obtaining and acting in accordance with the consent of people living at the home. Regulation 18.**

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 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The design and layout of the environment was not suitable to the needs of some of the people living in the home. Regulation 15(1)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Some of the people living at the home were not treated with compassion, dignity and respect, and included in decisions related to their care. Regulation 17(1)(a)(b)(2)(c)(ii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The individual needs of people living at the home were not always met. Regulation 9(1)(b)(i).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People living at the home were not provided with appropriate opportunities and support to promote their independence and community involvement. Regulation 17(i)(g).**