P & C Care Limited

The Mount Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected The Mount Nursing Home on 8 January 2015 and the visit was unannounced.

Our last inspection took place on 28 January 2014 and, at that time, we found the regulations we looked at were being met.

The Mount Nursing Home is a 40-bed service and is registered to provide accommodation and personal care for older people, people living with dementia or mental health conditions. Nursing care is provided. At the time of our visit there were 32 people using the service and one person was in hospital.

The accommodation for people is arranged over two floors. There are single and double bedrooms and some rooms have en-suite toilet facilities. There are communal bathrooms and toilets throughout the home. The communal rooms are on the ground floor and consist of two interconnecting lounges and dining room. There is also another lounge that gives direct access to the garden.

The home has a registered manager who is also one of the owners. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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. We found the deputy manager was in day to day control of the home.

We found the service was not well led. The registered manager did not visit during the inspection. The quality systems that were in place were not effective. There were no 'lessons learnt' from accidents and incidents to demonstrate what action had been taken to try and prevent them from reoccurring.

The office was disorganised and felt chaotic. Records that we requested on the day of our visit the deputy manager had difficulty locating or could not be found.

We found people's safety was being compromised. Procedures to keep people safe were not being followed. We were concerned about fire procedures in the home and following our visit we asked the fire officer to visit.

The communal areas smelt strongly of stale urine and some areas of the home were not clean. We also found the home was not well maintained and identified areas that needed either repairs or replacements during our visit.

There were not always enough staff on duty to make sure people received the care and support they needed. Not all of the staff had received the training they needed and staff were not getting supervision or appraisals to help them identify areas for future learning and development.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

We saw care workers treated people kindly but found they did not always support people to be independent or to lead a dignified life.

There was very little on offer to keep people occupied or stimulated. For most of our visit people in the lounges were just sitting sleeping or staring into space.

The risks to individual people living in the home were not well managed and appropriate action was not always being identified or taken to reduce or eliminate those risks.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff did not follow safeguarding procedures and there were incidents that should have been reported to the local safeguarding authority that had not been.

There were not always enough staff on duty to make sure people received the support they needed.

Although medicines were administered as prescribed they were stored at excessive temperatures that might have reduced the efficiency of the medicines.

The environment was not well maintained, there were areas that were unsafe and areas that were unclean.

Is the service effective?

Inadequate

The service was not effective.

Not all of the staff had received all of the training they needed to care for people effectively and staff were not receiving supervision or appraisals.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

Staff were not able to deal effectively with people's behaviours that challenged the service.

People's nutritional needs were met. People told us they enjoyed the food and we saw staff monitored people's dietary intake where they were at risk of weight loss.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always being supported to lead their life with dignity or to maintain their independence.

We saw individual care workers treat people with patience, care and tenderness. People using the service and visitors told us they liked the staff and found them kind and helpful.

Is the service responsive?

Inadequate

The service was not responsive.

Summary of findings

Staff were completing some assessments to identify risks to individuals but were not always taking appropriate action to reduce those risks.

There was very little on offer to keep people occupied, stimulated or entertained. We found people just sitting in the lounges sleeping and not engaging with anyone or anything around them.

A complaints procedure was in place but no complaints or concerns had been recorded.

Is the service well-led?

Inadequate 

The service was not well-led.

The registered manager was not in day to day control of the home.

Not all of the records we asked for were available and staff had not been notifying the Care Quality Commission about incidents that had happened at the service.

Although there were some systems in place to look at the quality of the service these were ineffective and had not identified many of the areas for improvement that were identified during our visit.

The Mount Nursing 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 January 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience in dementia 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.

Before the inspection we reviewed the information we held about the home. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of our inspection we spoke with twelve people who lived at The Mount Nursing Home, four relatives/visitors, two nurses, one senior care worker, three care workers, two cooks, the handy person, the activities coordinator, the deputy manager and operations manager.

We spent time observing care in the lounge and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included five people's care records, four staff recruitment records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Before our visit we looked at the notifications we had been sent by the service. We found they had not told us about any safeguarding incidents that had happened at the service since 21 January 2014. When we spoke to the safeguarding team in Bradford they told us they had received nine safeguarding alerts since our last inspection visit in January 2014. During our visit we looked at the incident and accident records and found 20 incidents that should have been referred to the safeguarding team. These included incidents where people using the service had hit each other, pushed people over, had unexplained bruising and one incident when staff had heard screaming and found one person squeezing another person around the neck.

During the morning we heard one person shouting, "Nurse" continually in the dining room. Another person was eating their breakfast and told us, "I've got to put up with that all of the time [meaning the person shouting out]. I can't stand it." They then shouted, "Bloody shut up," and there was a verbal exchange between the two individuals. The person who had been eating their breakfast then left the dining room. We went to speak to the person who had been shouting and they told us, "They will play hell and lose their temper now. When they lose their temper they hit you (this was demonstrated as a punch on the inspector's arm)." Then continued, "It would be wonderful if I could get out of here and live a quiet life. I haven't told anyone they hit me, I don't like telling tales." There were no staff present in the dining room to witness this exchange. Following our visit we referred this incident and disclosure to the local authority safeguarding team and also advised them that staff have not been reporting incidents to them. We also made six further referrals based on other observations during our visit.

If safeguarding referrals were not being made this meant external agencies were unable to consider the issues raised in order to decide if a plan to keep people safe was required. This put people at risk of continued incidents of abuse.

This breached Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found risk assessments had been completed for people to identify if they were at risk of malnutrition or of developing pressure sores. We saw some people had specialist mattresses on their beds to help prevent tissue damage. However, when we looked at some people's weights we found their mattresses were not on the correct settings. This meant the mattresses would not have been effective.

This breached Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The deputy manager told us one of the biggest issues to be addressed was the. "Refurbishment of the Home". They told us it had started, "We've replaced some of the floor but want to make the home more user friendly, including restyling the dining rooms."

Two visitors and two staff pointed out delays in sorting out practical repairs. Examples we were given were; waiting over six months for a key coded lock on a landing door to be fixed which still had not been repaired at the time of our visit and the new gas cooker still sitting, "For several months" in the kitchen waiting to be installed.

We spoke with the handyperson. They told us they were new and had only been working at the service for six weeks, following the previous handyperson's departure. We asked how they prioritised tasks. They said, "I mostly look around and fix things that looked like they need fixing."

We looked around the building and found areas that were unsafe. In two bedrooms we saw the sash cords on the windows were broken. In another bedroom we saw the window was being wedged open with a packet of incontinence pads. We found radiators with no guards on them and found them to be very hot to the touch. In one of the toilets we saw exposed hot and cold water pipes and the protective casing propped up against the wall.

We saw ripped floor coverings in some bedrooms that were posing a trip hazard to the people occupying those rooms and staff.

We saw a number of fire doors which were not closing securely into the door frames. This meant the effectiveness of these doors to hold back smoke in the event of a fire had been reduced. We saw a large amount of old furniture was being stored in the delivery entrance. This increased the 'fire load' in this area. We raised our concerns in relation to fire safety with the West Yorkshire Fire Service.

This breached Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

On arrival there was a strong smell of stale urine in the communal areas of the home and this prevailed throughout our visit.

In the kitchen we saw most of the tiles were missing from the walls exposing bare tile adhesive and plaster. This meant the walls could not be cleaned effectively. We found some of the tables people had in front of them had encrusted food on them and there was dried food underneath the arms of the dining chairs.

We saw a light fitting on the first floor with three uplighter shades. One of these shades was a quarter full of dead flies. In one bedroom we saw the two fluorescent light fittings were also full of dead flies. We also found a number of lights that were not working.

We looked in the ground floor bathroom at 9:35am and saw a plaster in the bath, hairs on the bath seat and used wipes on the side of the bath. The wash hand basin was very dirty and was covered in wet black residue and a piece of string. It looked like the mop bucket had been emptied down it. We looked at the bathroom again at 3:30pm and the bath and sink still had not been cleaned.

In one of the ground floor corridors, which was in use, we saw the flooring was a mixture of dirty carpet, followed by a square piece of plywood screwed to the floor followed by a considerable length, 20 feet or so, of bare cement floor. The carpet had several bits of what looked like clean white rolled up toilet paper scattered along it. The bare cement floor was dirty with many small amounts of dust and dirt all along it. This corridor was in a state of general disrepair with splashes of dried paint left on a bedroom door and on the edging of various lengths of wooden architrave. A toilet door had a sliding vacant /engaged sign which was partly covered in paint and was partly jammed in one position by that paint. Early in the afternoon this same corridor also had a foul and pervading smell of faeces.

This breached Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We arrived at the service at 7:30am and there was one nurse and and two care workers on duty. The nurse told us there should be three care workers on duty at night and this was confirmed by the manager. We looked at the duty rotas and saw there were some nights when three care workers were on duty and other nights when there were only two. We asked the manager about this and they told us there should be three care workers on duty with a nurse.

We spoke with a care worker on day duty and they told us there would usually be six care workers on duty during the day with a nurse but there were only five care workers on duty on the day of our visit. One care worker told us, “We could do with extra staff especially to help out in the mornings.”

We looked at the duty rotas and saw staffing levels were not being consistently maintained.

We saw staff were busy throughout our visit and were not always available in the communal areas to provide supervision and assistance to people. When we were looking around the building at 10:10am we heard someone in a bedroom shouting. We went in to see them and they told us, “I don’t know who’s about and I don’t know what to do.” They also told us they had not had any breakfast or a drink. We found a member of staff and asked them to bring this person a drink. At 2:20pm we were upstairs again and heard the same person shouting out again. This person did not have an emergency call bell within reach on either occasion and there were no staff in the vicinity to hear them and to respond.

At 10:55am one of the people using the service alerted staff that someone was out on the patio area. This was a secure area that was accessed from the small lounge where people went to smoke cigarettes. There was a digital lock on the door and once outside people had to wait for staff to let them back in. It was a cold day and the person had gone outside without a coat and staff were unaware they had gone outside.

This meant there were not enough staff on duty to meet people’s needs and keep people safe.

This breached Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the recruitment records for four staff members. We found that recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. This meant people who used the service were protected from individuals who had been identified as unsuitable to work with vulnerable adults.

During our visit we looked at the systems that were in place for the receipt, storage, disposal and administration of medicines. We saw a monitored dosage system was used

Inadequate

Is the service safe?

for the majority of medicines with others supplied in boxes or bottles. We looked at the medication administration records and found these had been completed consistently to show people were receiving their medication.

We observed some of the morning medication being given and saw the nurse spending time with each individual offering support in a calm and reassuring way. We did however note the morning medication round took four hours to complete. This meant some people did not get their morning medication until lunchtime.

We found medicines were kept securely but not stored safely. We looked at records that showed the temperature of the medication fridge had been maintained at the correct temperature. However, the recording of room temperatures indicated that medicines were stored at a temperature in excess of the upper safe limit. This situation had been known to the provider for over a year yet no remedy had been found. This meant the effectiveness of people's medication could have been compromised as it had not been stored at the correct temperature.

We recommend that the management of medication is reviewed in line with the National Institute for Health and Care Excellence (NICE) Guidelines for Managing Medicines in Care Homes 2014

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told by the deputy manager one person using the service was subject to authorised deprivation of liberty, The application had been made because the individual wanted to return home and kept asking to do this. An authorisation had been put in place for the person to stay at The Mount Nursing Home. This authorisation expired on 5 August 2014. The paperwork suggested a further authorisation had been applied for; however, the documentation could not be found.

We asked the deputy manager how many people lacked the mental capacity to make informed decisions. They gave us 17 names of people who used the service. However, when we looked at the care plans there was no information to show how people's capacity had been assessed.

We found the external doors and many of the internal doors had key pad locks on them. This meant people's movements within the home were restricted. We saw the door by the nurses' office was closed during our visit and we saw people who lived at the home becoming very frustrated that they could not get through this door.

We also saw there was a key coded lock on the door that led to the patio. This was a secure area that some people were using as a smoking area. We saw people were 'let out' by staff and then had to wait outside for staff to let them back in. This meant people were dependent upon staff to get back into the building.

One person told us they had the codes to the internal doors but did not have the codes to go outside.

We asked the nurse on duty if anyone was receiving their medication covertly. They told us they had permission from the GP to open one person's capsule of medication and sprinkle it on their yogurt. There was no information in the medication administration file about this or information about who had been involved in making this decision.

This breached Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw examples of staff not dealing effectively with challenging incidents between people who used the service. Some of the incidents could and should have been predicted and several incidents involved the same person.

At approximately 11.30am we saw one person sitting at a small dining room table swearing at the other person sharing the table and complaining that the other person had stolen their plate and cup. This continued for about 15 minutes. Staff were regularly passing by, as they continued to serve breakfast, and did not intervene. Eventually the situation deteriorated and the verbally aggressive person suddenly shouted and dramatically swept a cup of tea onto the floor. No staff were in the room at this point but the shouting caused two staff to run in to the room. One retrieved the cup and the other briefly sought to pacify the person who had become distressed. Both care workers then quickly went about their other business again. At this point the distressed person once again started at a low level but continued to verbally abuse the other person. Care workers, who were again routinely passing by did not intervene.

At lunchtime we saw one person leave their dining chair taking their plate with them to sit at another table. They then proceeded to move around the dining room verbally distracting and touching several other people who were trying to eat their lunch. Most clearly did not want or like this interference. Throughout this period there were between two and four care workers supervising the dining room. Not one care worker chose to seriously intervene and indeed several periodically chatted briefly to this person as they moved around and care workers continued to serve food. One care worker on hearing this person swear said to the room in general rather than the individual, "No swearing please" but did not follow it up as subsequently this person, periodically, continued to swear within earshot of staff.

We witnessed an altercation between two people in the dining room regarding one person's zimmer frame. We saw both people were shouting, swearing and physically tussling to gain control of the zimmer frame and this resulted in one person's foot being hit by the zimmer frame. No staff were present but came when they heard the shouting. One staff member escorted one person to another lounge. However, the other staff member just stood near the person who had been left, did not interact in any way and after a few minutes walked away.

Inadequate

Is the service effective?

After lunch we saw one of person interrupt two visitors who were sitting talking to someone in the lounge. This individual started touching and stroking the person who used the service around the face and upper body. This only stopped when the visitors got up to leave. A care worker was sitting talking to another person in the room and did not intervene.

At 3:00pm we witnessed another altercation between two people who used the service. This involved shouting and a tussle over a walking stick. A care worker did intervene and led one person away. However, the care worker then quickly left leaving people unsupervised again.

This showed us care workers did not have the skills or experience to anticipate or respond appropriately to behaviours that challenged the service.

We saw policies were in place regarding staff supervision and appraisals. These stated staff should receive one hours supervision every two months and an annual appraisal. We were unable to find evidence in staff files of a structured approach to formal supervision and annual appraisal. Discussion with the acting manager confirmed that supervision was not conducted at regular intervals and that appraisals were overdue.

Staff we spoke with confirmed that supervision and appraisals were not a regular feature of their employment. This meant staff were not being provided with a formal support system to look at their individual practice and professional development.

We spoke with the deputy manager who told us one of the key issues that needed to be addressed was the need for more, “Staff retraining including that about residents with dementia and learning disability.”

We spoke to the activity coordinator who was new to the role and was also working as a care assistant. They told us they had received no prior preparation to do the activity work, neither had they sought or been asked or encouraged to visit any other services to talk to and watch how other such coordinators or similar did their jobs. They told us there was a distance learning course they could do to learn more about it and which they would undertake sometime in the future. They told us the job was in any case mostly, “Common sense.” They told us they were finding out about the role by, “Googling” it at home and then coming in and trying things with people who lived there.

We looked at the training matrix which showed staff had received training in relation to adult safeguarding and person centred care. However, our findings on the day of our visit showed this training had not been effective as safeguarding incidents had not been recognised by staff and people were not being supported to lead dignified and independent lives.

We also saw staff had received training in dementia care and challenging behaviour. Again on our visit we did not see staff supporting people effectively as highlighted in this report.

This breached Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we looked at the recruitment records we saw the registered nurses had supplied proof of current registration with the Nursing and Midwifery Council (NMC). We also saw there was a procedure in place to make sure annual checks were made with the NMC to make sure the nurses remained on the register to practice.

Three people we spoke with told us the following about the meals; “It’s lovely here, the food is beautiful,” “The food’s alright anything you need just ask” and, “The food’s alright here.” A visitor said, “Resident’s appeared well fed.”

There was no information on display about what meals were on offer on the day of our visit. Some people were eating breakfast when we arrived at 7:30am. We saw the dining tables had tablecloths on them, placemats and serviettes but had not been set with any crockery, cutlery or condiments.

We spoke with the two cooks who told us they were providing soft diets, diabetic and three halal meals. They explained they fortified some foods with double cream to increase people’s calorie intake. We asked if staff made them aware of people’s individual preferences. They said this did not happen and often it was not until meal times when staff would make specific requests.

When we looked in people’s care plans we found very little information about people’s preferences in relation to food and drink. At breakfast time one person told us they had been given tea to drink but they preferred coffee. We saw another person had been given a jug of blackcurrant juice in their bedroom. They told us they did not like blackcurrant juice and preferred orange or lemonade.

Inadequate

Is the service effective?

Over lunch we saw a care worker checked with other care workers serving food to establish what food people had eaten, how much and whether there were any issues such food refusal. These comments they noted in a book. This meant care workers were monitoring people's food intake to make sure they were eating enough.

When we looked at people's care files we saw people had been seen by healthcare professionals such as GPs, occupational therapist, psychiatrists and dieticians.

Requires Improvement

Is the service caring?

Our findings

There was no information in people's care files about people's life histories or their personal preferences and interests. This meant there was no written information for staff to refer to. The deputy manager told us they had started to collect this information and showed us profiles for two people. These profiles were in the office and were not readily available for staff to refer to.

Care workers told us they did not read the care plans but got information about people using the service at verbal handovers between shifts. We listened to the handover between the night staff and day staff and found it detailed and informative.

Some people who had complex needs were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. We saw in their direct dealings with people staff approached them with respect. However, when we looked around the service we found issues that showed a lack of regard for people. These were some examples: People were given cups but no saucers and people were left to walk around still wearing the clothing protectors that had been put on when they were eating a meal. In two of the double bedrooms we looked at we saw the privacy curtaining between the beds only reached the top of the mattress. This meant people could not be fully private.

We looked in one of the bathrooms on the ground floor and found the lock did not work. There was a toilet cubicle in the same room which did not have a door on it. On the first floor there was a bathroom with two doors leading into it. Neither door had a lock on it. This meant if people were using these rooms anyone could walk in.

We noticed in several of the communal bathrooms that people's personal items had been left on shelves including razors, shaving foam and a used, crumpled and dry crunched up flannel.

Many of the people using the service required support to meet their continence needs and used pads and special pants to keep these in place. We found no-one had their own supply of 'net' pants but these were used communally. The laundry assistant confirmed this was the case.

We observed occasions when care workers were not supporting people to be independent. These were some examples:

In the morning, whilst in one of the lounges we saw a care staff give one person their drink. The care worker put the drink to the person's mouth. The individual told the care worker they did not want to be fed and could do it themselves. The care worker initially persisted in trying to put the drink to the person's mouth. The individual then raised their voice, tried to stop the carer worker putting the cup to their mouth and eventually the care worker relented. The person then proceeded to perform the task of putting the cup to their lips, drinking the liquid and putting the cup back on the nearby table, perfectly well on their own.

Over lunch a care worker told us that irrespective of each person's needs and capabilities staff took everyone's food orders from them when they were sitting at the dining tables. The care workers then went to the kitchen serving hatch and took the cooked food to each person's dinner table. At the end of lunch care workers returned the dirty plates back to the kitchen counter. The care worker then added that it was, "Easier" to manage lunch that way even though they were aware some people had been used to looking after themselves, including largely managing their own dining experience, having previously attended rehabilitation centres.

We spoke with one person who told us they loved their independence and doing things for themselves. This person used a travel mug, with a lid, to enable them to pick up and drink liquid without spilling any of it. In the afternoon we saw a care worker bring them a full mug of fluid with no lid on it and tried to feed it to them. The liquid was too hot and the individual burnt their mouth. The care worker, who was a full time member of staff, should have known this person needed the mug with the lid in place and could drink independently. This meant the care worker was not promoting the individual's independence.

This breached Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although we saw care workers did a lot of physical and practical caring tasks they actually gave very little personal time to provide support or nurturing. We saw brief conversations between care worker and people who used the service as the care staff went about their practical

Requires Improvement

Is the service caring?

caring tasks. These brief words spoken by care workers, often said only in passing did not add much in the way of personal valuing and sense of worth to the people in their care nor leave them feeling they were an important part of a close, warm family community.

People using the service told us they liked the staff. One person said, “The staff are very good. Most of them are cheerful and have a bit of a laugh.” Another said, “The staff are alright.” Three visitors made the following comments

“The staff are fabulous-every single one of them and the deputy manager is lovely.” “The staff are lovely, helpful, cheery and understanding.” “The staff are great and friendly.”

We saw individual care workers treated people with patience, care and tenderness. One care worker told us, “The best parts are that I love my job and the residents and that the staff get on so well together.”

Inadequate

Is the service responsive?

Our findings

There was no evidence in the care plans of people being involved in planning their care and support.

We saw in one person's care plan they were a diabetic and needed to have their blood sugar tested every week. When we looked at the records of their blood sugar levels we saw these had not been done on a weekly basis. This meant staff were not checking that the management of their diabetes was effective.

We found two single bedrooms on the first floor that had an interconnecting door between them, which was not locked. There was a male in one room and a female in the other. There was no risk assessment in place to show how staff had assessed the safety of this arrangement.

This breached Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people how they spent their time at the service. One person who was sitting in the dining room said, "There is nothing to do, I'm fed up. I haven't got a good friend." Another person said, "I just wish there was more entertainment." A third person told us, "There could be more activities."

We saw little in the way of any individual or communal encouragement by staff to stimulate people using the service by engaging them in social and leisure activities. Most people sitting in the lounges spent all the time we were there sitting alone, sleeping or staring into space. A TV was on continually in two of the lounges. But this seemed largely to form a backdrop of 'music' rather than be a source of particular interest to people.

The only exception to this occurred early in the afternoon in one lounge where the activity coordinator, briefly though unsuccessfully, tried to engage two people in table games whilst a third was drawing. One of these two people quickly left while the other person did not really engage with the coordinator. The coordinator eventually gave up and the attempt at activity ceased. This meant for a lot of people they were sitting in the lounges with just the television on and were not getting any meaningful, personalised activity.

The deputy manager told us the new activity coordinator had been appointed about eight weeks earlier as the service wanted to re-develop the range of activities for the people who lived there. The service had been without such a coordinator for a while. The new coordinator was an existing care worker who was 'doubling up' initially until they could more fully develop the role. The emphasis we were told would be on activities being 'resident led' and with considerable 1-1 contact.

We asked people who lived at the service if they were unhappy about anything or needed to make a complaint who would they talk to. One person told us they would tell a member of staff and others told us they would tell a relative so they could sort it out. We saw a complaints procedure was in place and a copy was in the front entrance hall. This area was not accessible to people using the service as the door to this area was locked, with a key pad. We asked the deputy manager how complaints and concerns were managed. They told us minor concerns would be documented in people's care files and would be dealt with. They told us there had been no complaints. However, in the absence of a log of concerns or complaints it would not be possible for the provider to spot any particular themes or trends. We noted the relative's complaint about the broken key pad lock had not been documented as a complaint or responded to. This meant there was no guarantee complaints would be identified and dealt with to people's satisfaction.

This breached Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The registered manager is also one of the directors of the company. We saw the registered manager was not on the duty rota and they did not come to the service on the day of our visit. Some staff told us the registered manager, “Popped” in most mornings whilst others said, “They call in now and again but not every day.” People referred to one of the nurses as, “The manager" and the person they would go to for support and guidance. We asked one of the people using the service who was in charge and they told us it was the deputy manager. For the purposes of this report we have referred to them as the deputy manager. This means the person with the legal responsibility for the management of the service was not in day to day control of the service.

Two visitors told us that they could not recommend the service due to poor overall management of issues especially by the owners.

We asked the deputy manager for the accident and incident reports. They told us these were held on the computer and we would have to go into each individual’s record in order to see these. This was not the case and inspectors were able to access all of the records. There was no analysis of accidents and incidents taking place. This meant no one was looking at any common themes or trends or putting measures in place to reduce the risks to people using the service.

We asked the deputy manager how they got people’s views about the service. They told us a survey had been completed in April 2013, however, when this was produced it was a staff survey. We asked the manager again how they got feedback and views from people using the service and relatives. They did not refer to getting the views of people using the service and we were shown a survey that was directed at relatives. We were told the previous year this survey had been organised by the owners of the service but this year the deputy manager was taking responsibility for this. We asked them how many relatives had responded to the most recent survey. The deputy manager did not know. We asked what issues in general did relatives raise. The deputy manager could not recall. We then asked about what had been done in response to the feedback from relatives. Again the deputy manager could not recall. They said that all the information relating to the survey was in a file in their office; however, this information was not produced for us. The deputy manager said, “I’m sure that everything relatives raised has been actioned.” This showed people’s views about the service were not actively being sought or acted upon.

We saw notes of a ‘residents’ meeting that had been held on 2 January 2015 only four people had attended and the discussions were about a new chef starting, information about refurbishment and people’s requests for trips out were noted.

We asked to see the audits of the environment. We were told these were held on the computer but these could not be produced.

During the inspection we found issues in a number of areas such as with the premises, infection prevention, planning and delivery of care, safeguarding, staff training and support. If there were effective systems in place all of the issues should have been identified by the provider and measures put in place to ensure they were rectified.

This breached Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found records were not readily available and could not be located promptly. The inspectors were requesting records from the deputy manager and these were not produced.

This breached Regulation 21 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found staff had not been notifying the Care Quality Commission about safeguarding incidents or about a Deprivation of Liberty authorisation. Providers are required by law to notify us of any incidents as identified within regulation 18 of the

Inadequate

Is the service well-led?

Care Quality Commission (Registration) Regulations 2009. We have written to the provider to inform them that any failure to notify in the future will result in enforcement action.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People who used services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).**

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People who used the service were at risk from living in a home where appropriate standards of cleanliness and hygiene were not being maintained. Regulation 12 (2) (C) (I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff had not received appropriate training to enable them to deliver care safely and to an appropriate standard. Staff had not received appropriate supervision, professional development or appraisal. Regulation 23 (1)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **Suitable arrangements to recognise and respond to people's complaints had not been made. Regulation 19 (1) (c) (d)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Suitable arrangements had not been made to ensure accurate records were maintained or that records could be located promptly. Regulation 20 (1) (a) (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People were not safeguarded against the risk of abuse. Regulation 11 (1) (a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People who used the service were at risk because there were not enough staff to care for them and keep them safe. Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Suitable arrangements had not been made to ensure people's privacy, dignity and independence were maintained or that people were involved in making decisions about their care or treatment. Regulation 17 (1) (a) (b) and (2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who used the service were at risk from not receiving care that met their individual needs or kept them safe. Regulation 9 (1) (b) (i) (ii)**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People using the service were not protected against the risk of inappropriate or unsafe care and treatment because the quality systems were not effective and risks were not being identified or managed.
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not ensure there were suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18