Meridian Healthcare Limited

Amber Lodge

Inspection report

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Date of inspection visit: 30 January & 5 February 2015
Date of publication: 21/04/2015

Ratings

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

Overall summary

The inspection took place on 30 January 2015 and 5 February 2015, both days were unannounced.

Amber Lodge provides accommodation and care for up to 40 older people living with dementia. The home is purpose built home and there is car parking available. The home is divided over two floors and people living there have single en-suite rooms. Both floors have communal lounges, dining rooms and bathing facilities. The home has a garden to the rear of the building which is secure.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not enough staff to sufficiently meet people's needs, this was of particular concern in the early morning when people were getting up for the day. We saw a number of people trying to get help from staff but they were unable to attract anyone's attention and people were not given a hot drink until 8.30am.

Summary of findings

During the day we saw a number of people were pacing up and down the corridors and staff were not available to try and interact with people and distract them from their distress.

Not all areas of the home were clean, this was a particular issue in the communal bathrooms. Some people's ensuite bathrooms had damage to the walls and we saw two ensuite bathrooms did not have towels or any other means for people to dry themselves. A visiting nurse told us they had difficulties getting appropriate equipment such as wipes, flannels and bowls to meet people's needs hygienically. The general décor of the home needed improvement, pieces of wall paper were peeling off and there were marks on the handrails and skirting boards.

The environment was not dementia friendly, there were limited opportunities for people to engage in stimulation around the home. There was some memorabilia around but this was limited. We saw some people upstairs in the home spent most of the day pacing up and down one long corridor.

We looked at the administration of medication and found people were being given their medication as prescribed. We found the recording of the medication administered was good. Staff told us they had received the training required to administer medication safely.

Staff were aware of how to protect people from harm and knew how to recognise and report abuse. The service had a safeguarding and whistleblowing policy in place.

People's nutritional needs were not being met. The food we saw was not appetising and people had limited choice. On the day we observed lunch the portions were small. We found people had lost weight and had not been referred to appropriate health professionals. In addition to this people who were supposed to be on a fortified diet were not routinely having this and the records of people's food and fluid intake were filled in later in the day, which could have an impact on the accuracy of the information recorded.

Staff had received training but this was not followed up with any assessment of competency and meant not all staff were equipped with the skills required to support people to live well with dementia.

Mental Capacity Assessments were recorded in people's care plans, however, some staff had limited understanding of what this meant for people they looked after. Deprivation of Liberty Safeguards had been appropriately applied for.

We saw care was not always delivered in a kind and compassionate way, people did not consistently have their dignity maintained. We did see some compassionate care and we saw work experience students had time to spend with people, which meant they were able to have conversations and quality time.

People had access to some activities but these were often interrupted as staff had to assist people with their personal care needs. The provider was looking to increase the hours of the activities co-ordinator.

People knew how to make complaints, and the service had staff and residents/relatives meetings which meant people could be involved in the service.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which has since been replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

There were not always enough skilled and experienced staff to meet people's needs. The personal evacuation plan was not up to date and had incorrect information recorded about people's abilities.

Not all areas of the home were clean and hygienic, and this meant there was a risk of infection spreading.

Staff knew how to recognise and respond to abuse safely, however, a member of staff told us about an incident between two people who used the service which had not been reported. Individual risk assessments were in place.

Medications were managed safely and administered in line with the prescribing recommendations. They were ordered, stored and disposed of correctly.

Staff recruitment policies ensured staff were suitable to work with vulnerable people.

Is the service effective?

Inadequate

The service was not effective.

People's nutritional needs were not being consistently met. When it had been identified people had lost weight, they were not always referred to a health professional. Some people had care plans recommending a special diet and we saw this was not always provided.

Staff had received training, but this did not equip them with the skills to support people living with dementia. We could not see any evidence of ongoing support and competency checks following the training.

The environment was not dementia friendly; there were some objects and memorabilia but this was minimal. Parts of the home needed the décor to be updated.

Mental Capacity Assessments were completed in people's care plans and DoLS had been appropriately sought. However, some of the staff we spoke with were not sure what this meant for people.

Is the service caring?

Inadequate

The service was not consistently caring.

We did not see people were routinely being cared for in a kind, respectful and caring manner which maintained their privacy and dignity.

Summary of findings

We observed some moving and handling practice which was poor and did not enable people to be involved in their care nor did staff provide people with adequate explanations about what they were doing and why.

Relatives felt they had been supported to be involved in the care for their loved ones and they told us the home was caring.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. We saw one person who was staying at the home for a short break did not have any assessment or care planning paperwork in place.

Activities were minimal, we saw people enjoy the interaction they had but staff often had to break off to support people with their care needs. The operations manager told us they were looking to increase the hours of the activity co-ordinator from 12 to 25 per week.

People told us they knew how to make complaints, one relative told us they had not made a formal complaint, but did not think the suggestion they had made regarding their relatives support had been implemented.

Is the service well-led?

Requires Improvement

The service was not consistently well led. During our inspection we did not see care staff being directed or supported by any senior staff members.

We saw evidence of policies and procedures across the service, however, we did not think these were being followed consistently.

Staff and Resident meetings took place which meant people were involved in the service. An annual customer questionnaire was completed so that people using the service could give their views.

The provider had systems for audits in place but some of these needed to be more robust to pick up the issues we found during our inspection.

Amber Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 inspection took place on 30 January and 5 February 2015, both days were unannounced. At the time of our inspection there were 36 people living at the home. On the first day the inspection team consisted of two inspectors, a specialist advisor in dementia care and an expert by experience in older people and people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two the inspection team consisted of two inspectors.

Before our inspection we reviewed all the information we held about the home. The provider had completed a provider information return (PIR). This is a document that provides relevant and up to date information about the home that is provided by the manager or owner of the home to the Care Quality Commission. We were aware of concerns that the local authority and safeguarding teams had regarding Amber Lodge Care Home.

During the inspection we spoke to nine people who lived at the service and six visiting relatives. In addition we used a Short Observational Framework for Inspection (SOFI) tool to help us understand the experience of people who used the service. After the inspection we were contacted by another two relatives who wished to provide feedback on the home.

We spoke to the registered manager, operations manager and operations director, and seven members of care staff. We also spoke with two visiting health professionals.

We spent time observing the medications round and care in communal areas of the home. We looked in some people's bedrooms, and ensuite bathrooms. We also observed breakfast and lunch on both floors of the home. We looked at documents and records that related to people's care, and the management of the home such as training records, policies and procedures. We looked at nine care plan records.

Inadequate

Is the service safe?

Our findings

Through our observations, talking with staff, people who used the service and their relatives we found there were not enough staff to meet people's needs.

On the first day of our inspection we arrived at 7.30am. The day shift started at 8.00am. Between 7.30am and 8.00am we saw three members of staff were supporting 36 people who lived at the service. We saw people tried to get help from staff but there were not enough staff available to meet their needs. One person was on the main corridor and was asking for help. The person was wearing a dressing gown which was unzipped and they had no clothes on underneath. A member of staff came out of another person's bedroom to help. At the same time another person came out of their bedroom and appeared distressed and confused, and asked, "where am I?". This went unnoticed by staff and we needed to find a member of staff to assist. The night care worker had to ask a member of staff from the day team to help, this was before their shift started.

In the main lounges we saw 10 people were up and dressed, not everyone was wearing footwear. Other people were then brought from their rooms to sit at the dining room table but no one was given a hot drink until 8.30 am. However, we saw staff made hot drinks for themselves.

On the first day of our inspection we told the registered manager about our concerns regarding staffing levels. The registered manager told us a number of staff had left recently including the deputy manager and two senior carers. The registered manager told us she did not like to use agency staff as she did not think they were effective, she said she would ask staff to cover extra shifts or use staff who worked next door at another of the provider's services. The registered manager told us she thought the service had adequate staff to meet the needs of people who lived there. She went on to say an additional six members of staff had been recruited recently, and she has booked a training day for February 2015.

On the second day of the inspection the registered manager was on planned leave and the provider had arranged for a manager from another service to provide management cover. We went through the rotas in more detail with the acting manager. They told us they needed three staff overnight, one of these should be a senior carer, and then six staff on the am and pm shift. We checked the rota for the three weeks before the inspection and found eight occasions when there were only two staff working overnight. There were a number of times when the day shifts did not meet the provider's minimum staffing level requirements.

The acting manager assured us her priority, and that of the operations manager, was the safety of the people who lived at the home. Between the first day of the inspection and the second day the newly recruited staff members had been for mandatory training and we were told, and shown on the rota, they had started to shadow care shifts.

Due to the staffing difficulties within the service; bank staff, new staff and staff from the service next door had been brought in to ensure the service was able to operate safely. On the first day of our inspection we saw a member of staff had been brought over from the sister home, and stayed until before lunch. They told us it was the first time they had worked at the service and they did not know the people who lived there. We observed the same issues on the second day of the inspection, one member of staff was unable to tell us how many people they were supporting.

There were not always enough qualified, skilled and experienced staff to meet people's needs. This is a breach of Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

We found areas of the home which were not clean. We saw one toilet had no lid and the seat was hanging off, there was evidence the toilet had been in use, which meant the person who used it was at risk of falling. We pointed this out to the manager who locked this and placed an 'out of order sign' on it immediately. In a shower room we noticed the grouting and tiles were not clean, the shower chair had stains underneath the seat, and in another bathroom we found debris down the side of the bath. A bathroom had sluice bags which had soiled laundry in them, and the handrail outside the sluice room was stained.

Some bedrooms had damage to the walls, and we saw two ensuite bathrooms did not have towels in them, so there was no way of people being able to hygienically clean their hands. In the corridors we noticed chipped skirting boards and some of the wall paper was peeling off. In the upstairs lounge we saw a radiator control was loose. The smoking

Is the service safe?

lounge, located upstairs, had visibly stained walls and the wallpaper was peeling off. We showed the operations director the décor and on the second day of our inspection this lounge was being re-decorated.

The community nursing team told us they never have access to paper towels or wipes in people's bedrooms so they brought their own. They told us people never have two flannels; one for their body and one for their face. They said this issue had been raised with the registered manager.

In the morning, we saw one person had a stain on the top of their walking frame, it looked like it could have been dried faecal matter. The stain was not noticed and cleaned by staff until we pointed this out before lunch. A relative, who contacted us after the inspection, told us they had found dried faecal stains in their family member's bedroom drawers, and that clean clothes had been placed on top of this.

These issues put people who used the service, staff and other people at significant risk of acquiring or transferring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatement.

Staff were able to tell us about what constituted abuse and had attended mandatory safeguarding training. They told us about the immediate action they would take if they witnessed abuse and were aware of how to report abuse.

However, one member of staff told us about an incident between two people who used the service which involved physical abuse. The member of staff told us they had taken immediate action to ensure the safety of the people involved and had reported the concern to a senior member of staff, but they did not think any action had been taken. We asked the supporting manager and operations manager if they were aware of the incident; they advised they had not been and agreed to look into it. The Care Quality Commission (CQC) had not been notified of the incident nor had the local safeguarding authority. There had been a further incident of alleged abuse between our inspection days, this had been appropriately reported to CQC and the local safeguarding authority. In addition to this the supporting manager had requested a medical review of the person, to ensure the behaviour which; was presenting a risk to themselves and others, was assessed. The previous incident had related to the same person who lived at the service, so there had been a delay in seeking the appropriate support.

We saw the fire evacuation plan was not up to date, one person was assessed as being independent, however, we observed they needed assistance of two people to mobilise due to their physical health. A number of people had been assessed as independent, and although they were physically independent, their dementia meant they would need significant support and supervision from care staff to be safely evacuated from the building in an emergency. We asked the manager who was supporting the home to prioritise a review of this, she agreed and confirmed this had been completed.

We found overall appropriate risk management processes were in place. There were risk assessments in place where areas of potential risk to people's general health, safety and welfare

had been identified. Where risks were identified, care plans were put in place which provided information to staff on how to keep people safe. However, we saw one person's moving and handling risk assessment was out of date.

Medication was administered safely, senior care staff were trained to administer medication, and we saw medication was being administered in line with the prescribing instructions. We observed the medication round and saw the member of staff respected people's dignity and privacy. We saw the staff member ask one person whether they were happy to have a cream applied in the main lounge or whether they would prefer to go to their bedroom.

We checked the medication administration records and found these were completed correctly. They contained a photograph of the person and information about any known allergies. The medication ordering system was safe, the service had a named worker at the local pharmacy who they could contact for any queries, medication was booked in by two senior members of care staff, and there was a safe system for storing medication which needed to be disposed of.

The medication trolley was locked and secured to the wall in a medication room. The home used a dosette system, which is prefilled by the pharmacy, and we were able to find medication easily. In the side of the trolley door we saw three inhalers and a container with eye drops, these

Inadequate

Is the service safe?

were not labelled. We spoke to the registered manager who agreed this was a risk and said she would rectify this. The controlled drugs cupboard was secure and all of the medication was correct and signed in and out by two members of staff. We saw medication was correctly stored in the fridge which was locked, one medication was in the fridge which did not need to be, we raised this with the registered manager who rectified this.

The service had effective and robust recruitment systems in place, we looked at three staff files and saw records of the checks made before staff were employed. The registered manager had obtained written references and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that holds information about criminal records and information which would help the service check if staff were suitable to work with adults who were vulnerable.

Inadequate

Is the service effective?

Our findings

On the first day of the inspection we observed lunch on both floors. We had asked staff earlier in the day what people would be having for lunch and they did not know. We saw a menu board downstairs in the lounge. We were told people made their choices the day before. People had two main meal choices, there was no starter. The main meal was either cheese and onion pie and chips, or fish, chips and mushy peas. The majority of people had the fish option, we observed the portions looked small, and there was no extra, readily available, if people wanted more. A member of staff told us, "Everything is done on a tight budget."

There were two options for dessert; people were asked whether they wanted 'flan' or sponge and custard. We saw a number of people found it difficult to make the choice and staff responded by saying it again, we observed one member of staff gave the options again to one person, however, they simply said it louder. We did not see any staff member assist people to make the choice by showing them the options.

The only drink people were offered with their lunch was orange squash, one person said, "I hate this juice I like fresh orange". They were not offered an alternative.

People had adapted cutlery, where needed, to enable them to eat independently. We saw that a menu sheet was used each day to order lunch and tea. This included any special diets that people were on such as diabetic, low sugar, soft and fortified diet, a note on the order sheet explained that 'fortified' meant people should have milk, cream, full fat yoghurts and high calorie snacks.

A member of staff told us nine people who lived on the second floor had food and fluid charts. We asked the member of staff why one person had a food and fluid chart, and they explained that the person had lost weight, they said, "Some days [the person] just sleeps all day and doesn't eat, other days [the person] walks around and eats everything." We looked at the care plan for this person and could see they had progressively lost weight over a six month period; in June 2014 the person weighed 72.3 kg and in January 2015 their recorded weight had dropped to 63.4 kg. Their care plan recorded a fortified diet and daily food record was required. Their food intake record did not show any fortified drinks or diet had been offered during the previous two months. In addition it was not apparent from the charts that the person's food intake varied from day to day as the care assistant had informed us. We saw the person had seen their GP but there was no record as to what this was about or any follow up recommendations.

A member of staff told us another person was on a soft diet because they did not swallow lumpy food, and stored it in their mouth. We looked at the care plan and found the person had been assessed as being at risk of malnutrition and should be given 'high calorie snacks and fortified drinks'. The care plan did not show any record of the person storing food or needing a soft diet. The menu list that we were given did not show any dietary requirements for this person.

When looked at the food and fluid intake chart, this did not show any volumes of fluids taken, just 'tea' or 'juice'. There was no guidance for staff to help them know how much fluid the person should drink, and what to do if they did not drink enough. The chart did not show that any fortified or high calorie food had been taken. We saw the charts completed by care staff late in the afternoon and we concluded it would be difficult to recall accurately how much people had eaten.

A relative contacted us after the inspection, they told us their family member had lost weight and had been seen by the dietician. They told us the dietician had prescribed food supplements, and that their relative should have finger foods and a fortified diet. The relative did not believe this was happening, they told us when they visited they helped their relative to eat and they always ate well.

People's individual needs were not being met in relation to their diet, when people had lost weight we did not see they were always referred to an appropriate health care professional. This is a breach of Regulation 14 (Nutrition and Hydration); Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned people were not being appropriately referred to health professionals, one person told us they had lost their bottom dentures and we saw another person had a sore mouth. We spoke to the manager who agreed to refer both people to the dentist.

We looked at a care plan for one person and noted a significant weight loss; in October 2014 the person weighed

Is the service effective?

43 kg and this had dropped to 34.4 kg on their last recorded weight. The person had not been referred to the GP or dietician. The registered manager told us this was because they had been on end of life care. However, we saw this was withdrawn by the GP on 4 January 2015, and the person had lost further weight since then. The registered manager agreed to refer the person to the GP.

This is a breach of Regulation 9 (Care and welfare of people who use the service); Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person centred care.

We looked at training records for five members of staff. As part of the induction training we saw one person had completed the following mandatory training on one day; safeguarding, dementia awareness, infection control, food hygiene and mental capacity and DoLS. We were concerned the training provided would not equip staff with the knowledge and skills needed because of the volume of learning in one day. We did not see any follow up or assessment of the person's competency following this training.

One member of staff told us she had received a talk on dementia from the registered manager, but did not feel they understood dementia and how best to support people. We asked the registered manager about dementia training for staff, and she told us she taught staff herself, from training that she has done in the past. We observed some interactions between staff and people who used the service which demonstrated staff did not have the skills to support people to live well with dementia.

One person living with dementia repeatedly said they were waiting to go home and walking to the front door, the person was given different responses from staff, one staff member said, "Your transport's not here yet", another said, "your transport will be coming later." None of the staff tried to distract the person with any activity. There were a number of people upstairs who spent most of their day pacing up and down the corridor, we did not see staff observing them or attempt to engage with them, even though they appeared distressed. We saw a member of staff try to take a handbag from someone, as it belonged to another person who lived at the service. The member of staff continued to try and remove the bag despite evident distress from the person. The staff member eventually persuaded the person to give her the handbag but the person was and raised a hairbrush at the member of staff.

This is a breach of Regulation 9 (Care and welfare of people who use the service); Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person centred care.

A visiting professional from the community mental health team advised us they did not think enough of the staff understood how to support people with dementia, and did not think the staff were sufficiently trained. They told us they had come to assess a person who lived at the service following an incident of behaviour that challenged the service. The professional told us this was a one off incident and that there were no records in the persons care plan of any behaviours that challenged. They told us one person who was pacing up and down the service was someone the community mental health team could support and the registered manager agreed to refer this person.

The environment was not dementia friendly, corridors had minimal reminiscence information for people to look at. We saw some football memorabilia on the downstairs corridor and upstairs had a couple of mannequins with vintage dresses on. Some bedrooms had names and a photograph on the door. Two of the bedrooms we saw just had a number. One person who lived at the service had no personal items on display in their bedroom, although they did not have any family or friends we could not see the service had attempted to support the person to personalise their room. We spoke with the operations director about the environment, he told us that he had been on courses about dementia friendly design and architecture. He said "It's very interesting, there's so much to learn, and so many angles to it. There's not much point in creating reminiscence corridors because they connect with people one day and not the next. It doesn't really make much difference."

The Mental Capacity Act (2005) (MCA) provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff had attended MCA training, but two members of staff we spoke to were not able to tell explain to us about the MCA. One member of staff said they,

Inadequate

Is the service effective?

"…didn't understand capacity really", and another staff member told us, "Not a lot of these [people who lived at the service] are compos mentis". There was no evidence staff knowledge and implementation was checked following completion of training courses.

We saw two of the staff members had attended further training courses on Dementia Awareness and a senior carer had attended a course on supporting people who have behaviours which challenge.

We spoke to the operations manager about training and they informed us the provider planned to roll out a training programme called HARMONY. They advised this would enable staff to have more in-depth knowledge of how to support people to live well with dementia.

We concluded the provider did not have suitable arrangements in place to ensure staff received appropriate training. This is a breach of Regulation 23 (training); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

We saw copies of mental capacity assessments in people's care plan records, these were completed in line with the code of practice. Assessments were made in relation to a person's ability to make a specific decision and relevant people were involved in the assessment and best interest decision making process. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

At the time of our inspection eight people who lived at the service had an authorised DoLS in place. We saw in the office these people had a 'D' marked next to their names. The authorisation paperwork had been completed correctly, and all of the necessary paperwork was in place. However, three staff we spoke with, all permanent members of the team, were unable to tell us how many people, or who, was subject to a Deprivation of Liberty Safeguard. They could not tell us what this meant for their care needs. One member of care staff identified two people who had a DoLS in place and when asked what this meant said, "…they [person who used the service] could not go out on their own". Despite receiving training we did not think staff understood DoLS and what this meant for people who used the service.

We looked at three staff files and found staff had received supervision at regular intervals, which was in line with the organisations policy. One member of staff told us they found the registered manager supportive, however, two staff members told us they did not feel supported and one member of staff told us supervision was used, "as a threat".

Inadequate

Is the service caring?

Our findings

The service was not caring. On the first morning we heard a senior care assistant say to someone, "you're wet, you bugger", the person's bedroom door was open. The person was not spoken to in a respectful manner, and their dignity and privacy was not maintained. We raised this with the operations manager who agreed to investigate the matter.

During our inspection two people were receiving end of life care. One person was nursed in bed and, whilst observing the morning handover we heard that the person was being turned in bed every two hours. We were told the senior care worker, overnight, had spent the night completing their paperwork on the person's room so they were not alone. We looked at this person's care plan but it had not been updated to reflect the person was end of life care, we raised this with the registered manager who updated this immediately. We saw the district nursing team were providing the nursing support to staff.

We saw three occasions where staff did not support people to safely mobilise. One person being supported to walk down the corridor by two members of staff, the person looked very unsteady and was being supported by a member of staff holding onto each arm. The person was trying to sit down whilst walking, and looked like they may fall. We intervened as we were concerned for the person's safety, and the manager brought a wheelchair. The person's care plan said they were independently mobile; we were told by staff the person had been unwell for the last few days, and their mobility had got worse. The GP had not been contacted, the registered manager agreed to do this as a matter of urgency.

We saw another person being supported to stand up from the chair they were sitting in so staff could turn over the pressure cushion, as the community nurse had pointed out this was upside down. A care assistant and the registered manager were at either side of the person and were holding the person under each arm. The person was struggling to stand even with support being provided by the two members of staff. It took two attempts to assist the person to stand, it did not look like a safe or comfortable experience for the person. We checked the moving and handling risk assessment for this person, dated 15 January 2015, it said, '[name of person] is able to stand and transfer with 2 people and a zimmer frame', and that a wheelchair was needed for mobility. We spoke to the manager about our concerns, they told us the person was not lifted. On the second day of the inspection we saw the person was supported by two other staff members, who used a manual handling belt to support the person, they were able to assist the person to stand on the first attempt, and the person looked much more comfortable.

Another person was asked by a member of staff if they would stand up, a senior care worker then said the person needed to be hoisted. The person was upset about this, and did not want to be hoisted. The care assistant told them it was, 'company policy', and for 'staff safety'. They did not offer a personal response such as, 'we're worried you might fall' and so the care worker missed an opportunity to reassure and involve the person in their care. The care assistant hoisted the person with a senior carer.

We saw a number of people who were not wearing any footwear, other than socks, we also saw one person was pacing up and down a corridor barefoot. One person had no shoes on and a hole in the leg of their trousers, and cardigan. We pointed this out to a member of staff and later in the day noted the person had been supported to get changed.

We did not observe people being supported to have their dignity and privacy maintained. One person came out of a toilet with one sock on, the toilet floor was wet. The person walked into the smoking lounge and we saw the tap was overflowing at the person had put their sock in the sink. We alerted a member of staff who came to support the person, they staff member told us the person, "likes to make plugs."

As we walked along the corridor when we saw a person standing inside the toilet with the door open pulling at something in their trousers. A few minutes later we noticed another person was bent down picking up small pieces of faecal matter, with their hands, from the toilet floor. We sought a member of staff and they came to support the person. The care assistant told us the first person frequently deposited the contents of their incontinence pad onto the toilet floor.

We did not see care was delivered in a manner which was kind or caring manner which maintained people's dignity.

This is a breach of Regulation 9 (Care and welfare of people who use the service); Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social CAre Act 2008 (Regulated Activities) 2014 person centre care.

Inadequate

Is the service caring?

However, visitors and relatives told us the service was caring. Two visitors we spoke to felt their relative was being well cared for. One person told us, "They look after [my relative] very well. They've been very good and I feel confident [my relative] is alright. There isn't a better place." We saw a senior care worker sit and talk with three people who lived at the service, the care worker was relaxed and smiling and people enjoyed the conversations.

We observed the handover in the morning; staff knew people well, they focused on people who were unwell and what action was required for that day. We saw some staff spoke to people who used the service in a kind and respectful way. A care assistant responded well to one person who was tearful because they wanted to see their family member; they offered reassurance and then appropriately distracted the person from their distress by having their nails painted. Whilst the care assistant was doing this they chatted along to the person and encouraged the other people in the lounge to join in and to have a chat with each other.

Visitors came throughout the day without restriction, most visitors seemed to come in the afternoon. One relative told us, "…I don't really get involved in discussions about [my relative's] care, but they sort of ask me every year, when they have a review." Another person told us staff had supported them to understand their relatives condition and felt supported and involved in their relatives care. They said, "I've learnt a lot from them about how to manage…they've helped me know what to do. I've never had any issues with the care. They've all been understanding…"

Requires Improvement

Is the service responsive?

Our findings

Most people had their needs assessed before they moved into the home. This ensured the home was able to meet the needs of people they were planning to admit. The information was then used to complete a more detailed care plan which should have provided staff with the information to deliver appropriate care. We saw care plans were reviewed each month.

However, one person had been admitted to the home for one week's respite care at the start of the week we inspected. We noted the person was displaying some behaviours, which we heard their relative tell a care assistant this was due to anxiety. We wanted to look at what was recorded for staff about how to support the person with this. We asked the manager to look at this person's care plan. The file was empty, other than a support plan from the local authority which was dated October 2014. The registered manager told us she had completed a pre admission assessment with the person and their relative but had not had time to write this up. The registered manager confirmed there were no care plans for the person. Therefore, staff were not aware of how to meet this person's needs. We checked, and found, an up to date MAR chart in place to ensure they were being supported with their medication.

There was no care plan in place and therefore, staff had no guidance on how to support this person. There was evidence of anxiety but staff were unaware of this and did not know how to reassure the person. This is a breach of Regulation 9 (Care and welfare of people who use the service); Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social CAre Act 2008 (Regulated Activities) Regulations 2014 person centred care.

Each care plan had sections which covered different areas of people's needs, for example; mobility, nutritional needs, skin integrity and personal hygiene. People who used the service had some basic preferences recorded such as their preference in relation to the sex of the carer who supported them with personal care. However, we found limited information on people's general like and dislikes and their life histories. This is important for people with dementia as care staff can use this information as a tool to aid meaningful communication with people.

The manager told us they employ an activities co-ordinator for 12 hours per week who worked on a Saturday and Sunday. When we spoke to the activities co-ordinator she told us she spent a day on each floor of the home. The operations manager informed us they had requested an increase in this to 25 hours per week and we were told this was currently awaiting approval for funding.

We saw an activities timetable available on each floor. In the upstairs lounge we saw a care worker playing ball games with people who lived there, however, this only lasted for about ten minutes as the care worker was then needed to assist someone with their personal care. In the lounge downstairs we saw a chair based exercise session take place, one member of staff was running this session again, they had to stop the session when one person got up to go to the bathroom. People who lived there enjoyed the interaction. On the first day of our inspection the planned afternoon activity did not take place.

We completed a SOFI mid-morning on the second day of inspection and observed a 45 minute period. We saw minimal staff interaction, one member of staff spoke to people about their drink of tea asking, "Have you finished with your cup of tea". The television was on but the five people we observed were not watching it, people were drifting in and out of sleep. Other than this we observed no interaction, during the SOFI, between staff and the people who lived there.

On the second day of the inspection the downstairs lounge was lively in the afternoon, some volunteers had come from a local bank to discuss the history of the area, and there were a number of visiting relatives.

The service offered work experience to students from Leeds College; during our inspection the service had two students on each day. They were able to spend time with people on a one to one basis, but were not available to support with their care needs. One of the students set up a chess set on the dining table and then asked one of the people who used the service to teach them how to play. The person seemed pleased to have been asked and became animated and engaged in the game.

We looked at the complaints book where complaints had been recorded, and saw a form to record what action and investigations had taken place, and whether the matter had been resolved and the person making the complaint had been informed. We saw that this had been completed

Requires Improvement

Is the service responsive?

for the last two complaints made and where appropriate letters and statements had been attached to form a full record. When we asked people who used the service who they would talk to if they wanted to make a complaint responses ranged from; “the staff”, “my relative” to “what’s the point”.

One person who lived at the service told us; “I get bored, there is never anything to do; I want to do some jobs”. The person had a relative visiting who told us that her relative would love to set tables or dust, and that she had raised this with the registered manager on several occasions however, nothing had been set up.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was present on the first day of the inspection, however, between the first and second day of the inspection she was no longer in post. The provider had arranged the manager from the sister home, Rievaulx House, to work in the role of acting manager this is on a temporary basis until new management arrangements are in place.

A visiting health professional told us that any suggestions made to the registered manager had always been acted on. However, one member of staff told us they saw the registered manager at the handover and that she was approachable most of the time but that, "She can get a bit uptight when stressed over a lack of staff."

Comprehensive policies were in place and were up to date, these included; safeguarding, whistleblowing, complaints and medicines. The supporting manager told us all staff were shown these on their induction and knew where to find copies of them, she went on to say all staff would have received a staff handbook which included the policy basics for safeguarding and whistleblowing. However we were not confident staff were following these policies based on the concerns raised about safeguarding referrals being made.

We saw the registered manager had conducted annual appraisals and a member of care staff told us they had talked about how they were doing; this was recorded as an individual learning plan. We saw evidence of these in staff files and they contained information on aim/goals, agreed training, timescales and employee and manager's signature.

There was a system in place to assess and monitor quality. The registered manager completed a monthly report electronically, this included details of any incidents or accidents, such as falls or pressure ulcers. The operations manager for the group of homes told us that any incidences were analysed for trends and fed back to managers. The operations manager completed a monthly compliance visit. They reviewed audits done by the registered manager, and made separate checks called Monthly Compliance Visits. Such as checking two care files and answering, 'Are consent forms signed?'. Unfortunately there was no check on whether the person had mental capacity or why they did not sign their own consent. All of the consent forms we looked at, for photography and personal care, had been signed by relatives.

An annual review led to an action plan which was reviewed every month. We saw that this stated in November 2014 that, 'All staff have now received refresher training on the basic awareness of MCA.' However staff we spoke with did not understand the practical implications relating to Mental capacity. The review also claimed that 'Dementia illness and symptoms along with management techniques are detailed in the care plan.' We did not find this to be the case in the care plans that we looked at.

People were given opportunities to feed back their views of the service. We saw evidence of the annual customer questionnaire issued centrally by the provider, together with annual resident questionnaire issued by the home.

The staff meeting documentation showed that these meetings were forums for communicating key information to staff and showed evidence that practice was challenged and the provider was seeking to improve the care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People's individual needs were not being met in relation to their diet, when people had lost weight we did not see they were always referred to an appropriate health care professional. This is a breach of Regulation 14 (Nutrition and Hydration); Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The service was unclean. This put people who used the service, staff and other people at significant risk of acquiring or transferring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff We concluded the provider did not have suitable arrangements in place to ensure staff received appropriate training. This is a breach of Regulation 23 (training); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not always enough qualified, skilled and experienced staff to meet people's needs. This is a breach of Regulation 22 (Staffing); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People did not receive adequate care to ensure their needs were met.This is a breach of Regulation 9 (Care and welfare of people who use the service); Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.