Runwood Homes Limited

Owston View

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

Summary of findings

Overall summary

The inspection took place on 18, 20 and 21 July 2016 and was unannounced, which meant the provider did not know we were coming. This was the first inspection of the service following the Care Quality Commission registration in September 2015. The service was previously registered under another provider.

There was a new manager at the home who became registered shortly after our inspection on 26 June 2016. The manager is also registered at another Runwood Homes Limited service in Doncaster and we were informed that they will be based at Owston View until further notice. 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.

Owston View is a care home situated in Carcroft, Doncaster which is registered to accommodate up to 36 people. The service was split into two units the Croft unit which cared for people living with dementia and Willow unit which had bedrooms on both the ground and first floor. This was classed as the residential unit. The service is provided by Runwood Homes Limited. At the time of the inspection the home was providing care for 21 people, some of whom had a diagnosis of dementia.

Concerns had been raised to us before the inspection in relation to staffing levels and an incident involving one person whose care needs had not been appropriately met. This was still being investigated at the time of the inspection.

At the time of our inspection we found there were not enough staff on duty to ensure people's care needs could be met in a timely manner. The system to alert staff when people needed assistance was not working effectively.

People cared for in bed did not receive appropriate care and treatment. Some issues identified on the first day of the inspection had not been addressed when we returned on the second day. Some people were at risk of being socially isolated due to their high dependency needs, the only interaction with staff was when staff were assisting with personal care tasks.

Care records were not always fit for purpose. Some lacked detail, were out of date or contradictory. When care records were reviewed, the reviews did not always result in relevant changes being made to people's care plans or risk assessments. We identified instances where care was not being provided in accordance with people's assessed needs.

Safeguarding arrangements in the home were in place. Staff we spoke with appeared to be knowledgeable and were trained in this area, and appropriate procedures had been followed when abuse or suspected abuse had occurred. However, during the inspection we identified safeguarding concerns which had not been recognised and we have report these to the local authority.

The manager was aware of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). There were policies and procedures in place and key staff had been trained. This helped to make sure people were safeguarded from excessive or unnecessary restrictions being place on them. We found some improvements were still required to ensure mental capacity assessments and best interest decision records were more detailed and decision specific.

Health professionals told us that communication within the home was poor. They told us their instructions were not always followed which meant people's care needs were not always met.

We found staff approached people in a kind and caring way. However, most of the interactions we observed were task orientated. People could not access activities. Staff told us they did not have time to arrange activities. Signage around the home was not dementia friendly. Notice boards were not kept up to date and menus were not always displayed.

The secure garden area was not safe for people to use. Old broken furniture, no shade and overgrown bushes meant people would be at risk of injury. People accessed the garden through fire doors which could not be opened from the outside, therefore people had to wait until staff were available to let them back in.

The provider told us systems were in place to guide staff on safe administration of medicines. However, we identified these were not followed and people did not always receive their medication as prescribed. Medication was not stored at the recommended temperature. Protocols for the administration of 'as required' medications were generic which meant they were not effective.

We identified that inadequate staff were on duty to meet people needs, although the provider did review this during our inspection. We observed people had to wait for assistance and staff were not always present in communal areas to ensure people's safety. Staff and relatives we spoke with told us they could do with more staff to ensure people's needs were met in a timely way and maintain their safety.

People were not always supported to eat and drink sufficient to maintain a balanced diet and adequate hydration. We found the meal time experience did not meet the standards expected by the provider.

Infection prevention and control policies were not always adhered to; therefore safe procedures were not always followed.

We saw the provider followed safe recruitment procedures to ensure people employed to work with vulnerable people were fit to do so. However, we found staff induction was not completed and staff had not received supervision in line with the provider's policies. Staff told us morale was very low which was impacting on the people who used the service.

The systems and processes in place to monitor the quality and safety of the services provided were not effective. There was a complaints procedure; however relatives told us that they were not satisfied with the standards of care. One relative told us they were not satisfied with how their complaint had been handled.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that

there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Individual risks to people were not assessed or mitigated.

Staffing levels did not enable people's needs to be met in a timely way or in keeping with their preferences. Staff were recruited safely but induction, training and development required improvement

Medicines were not managed safely.

Infection prevention and control measures were not effective

Is the service effective?

Inadequate

The service was not effective.

Staff lacked understanding on how to meet people's needs when they demonstrated behaviours that may challenge others.

Appropriate referrals had been made using the mental capacity and deprivation of liberty safeguards; however some MCA assessments lacked detail.

People's nutritional and health needs were not consistently met.

Is the service caring?

Inadequate

The service was not caring.

Care plans were not always up to date. It was difficult to determine if people's wishes were listened to or respected. There was minimal information available about people's wishes for the end of their life.

Staff were extremely task orientated. People cared for in bed were isolated and we observed aspects of people's care that was not undertaken in a dignified way.

Is the service responsive?

Inadequate

The service was not responsive.

People's health, care and support needs were no regularly assessed or reviewed. We found staff were knowledgeable on people's needs; however, most interactions were task led rather than person centred.

People were not able to access activities both inside the home and in the community.

There was a complaints system in place; however, relatives told us that they did not feel as though they were listened to.

Is the service well-led?

Inadequate

The service was not well led;

There was a distinct lack of leadership and direction within the service which had not been identified by the provider. Staff felt they were not listened to.

Health professionals told us communication was poor as some information had not been passed on that affected people's care and treatment.

Audits and checks of practice were not thorough enough to ensure people's needs were met. Systems and processes were not rigorous to ensure regulations were met.

Owston View

Detailed findings

Background to this inspection

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

This inspection took place on 18, 20 and 21 July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and we were joined on two days by a quality assurance officer from Doncaster council. On the second day of this inspection we were also joined by a senior clinical nurse specialist; infection prevention and control nursing and quality, from Rotherham, Doncaster and South Humber NHS Foundation Trust.

Before our inspection we reviewed all the information we held about the service. The provider had completed a provider information return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We also looked at concerns received from safeguarding and relatives and any statutory notifications we had received from the service.

During the inspection we spoke with three visiting district nurses and a tissue viability nurse for their views on the service. We spoke with the community psychiatric nurse who supported people with their mental health needs. We also contacted by telephone the pharmacist specialist who is part of CQC's medicines team. They gave us advice about the impact on people who used the service who had not received their medication as required by the prescriber.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at other areas of the home including the outside secure garden, some people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to peoples care, including care plans, risk assessments and daily records. We looked at five people's support plans in detail and also a further 12 people's care plans in relation to their food and fluid intake and 'as and when required' medication protocols. We spoke with eight people living at the home; some of them were unable to engage

with us fully due to their limited capacity. We also spoke with eight relatives to gain their views on the care provided.

During our inspection we also spoke with three care team managers, six care staff, the administrator, the cook and two general assistants. We also looked at records relating to medicines management and how the home monitored the quality of services. The regional care director was present for the three days of the inspection and the operations director north was present when feedback was given on the third day of the inspection.

Inadequate

Is the service safe?

Our findings

We spoke with people who used the service to assess if they felt safe in the home. Because most people were living with dementia some of their responses we have not been able to include. All of the relatives we spoke with expressed concerns that the care was not safe for their family members as they told us that they did not think there was enough staff on duty. One relative we spoke with said, "The staff are really nice but there is just not enough of them. Sometimes when I visit my [family member] staff ask me to 'just keep an eye' on the residents because the two staff have got to attend to someone who needs both their attention. That can't be right."

Throughout the three days of the inspection we carried out observations of people receiving care to assess whether there were staff in sufficient numbers to meet people's needs. We observed that at times people had to wait for assistance from staff, and there were lengthy episodes where people did not receive support when they required it. Staff were not always present in communal areas.

We saw one member of staff carried a pager which they told us alerted them to people that required assistance by activating their call bell. The member of staff told us that each member of staff should have a pager but only one was working and that only worked intermittently. We saw this was correct as when we attempted to go out of a fire door the pager did not pick up the call to say the door had been opened. The regional care director was with us as we tried to raise the alarm at different parts of the building.

One person was receiving end of life care and we had identified on the first day of our inspection that more frequent checks were required to ensure they received hydration. The regional care director had asked staff to ensure they were checked and offered a drink every 30 minutes to ensure their needs were met. Staff told us with staffing levels they would struggle to do this and fluids had not been offered frequently to ensure their needs were met.

Staff told us there was only two staff on duty at night from 10pm until 7am. The service was two separate units. Staff told us on Willow unit there were six people who required two staff to assist with personal care and moving and handling. They also told us that three people on Croft unit required assistance from two staff and five people regularly had disturbed sleep and continually got up during the night. This meant at night if staff were on Willow unit, people on Croft unit were left unsupervised and could be at risk of harm. Two people on Willow unit were also at end of life and required more frequent attention and checks by staff. Two staff on nights were not able to meet people's needs safely. We fed back our concerns to the regional care manager and the operations director north. Following a meeting with Doncaster council contracts manager the provider agreed to put an additional member of staff on duty during the night until they had reviewed the deployment of staff.

We also found that the accident log which commenced on 23 April 2016 showed a total of 39 recorded accidents with the majority having occurred on Croft unit and most were un-witnessed. This is a high number of incidents in a three month period and Croft unit only has ten people using the service. This suggests there are insufficient staff to ensure people are safe.

The regional care director gave us the latest copy of the dependency tool used to calculate staffing numbers, from June 2016. We identified that one person whose care plan we looked at, had deteriorated recently and their needs had changed from low to high. The dependency tool had not been updated. This meant if the dependency of people who used the service was inaccurate the staffing levels required were not being accurately assessed.

All staff we spoke with told us they could not meet people's needs with the number on duty. One staff member told us, "We only have two staff on Willow unit and my last shift I spent most of my time upstairs with [people receiving end of life care], there was no staff downstairs, puts people at risk." Another staff member said, "Many people take two staff to assist that means no staff are observing in communal areas."

Health care professionals we spoke with told us when they visited they always struggled to find staff and felt there was not enough staff on duty. One professional said, "I always like to hand over to ensure staff are aware of what is required so there is consistency with care. However, I am not very often able to find staff, sometimes I arrive go to my client and leave without seeing anyone."

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

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs).

We found medication storage rooms had reached temperatures above the recommended temperatures. The room temperature had reached 29 degrees centigrade on the day of our inspection and had been above 25 degrees centigrade on numerous occasions over the last month, which is the highest recommended temperature medicines should be stored at. We found on Croft unit medicines were kept in peoples rooms, the rooms were extremely hot; we asked a member of staff to check all the room temperatures and they were all also above the recommended temperature to store medicines. Staff did move the medicines out of the rooms and placed them in the medication room. However they were then still not stored at recommended temperatures. The provider has since our inspection informed us a portable air conditioning unit was being ordered.

We found a large number of medicines administration record (MAR) charts were hand written and these were not checked and signed by a second member of staff, which is good practice. We found staff who administered medicines did not always record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, for pain relief and to alleviate agitation. We saw PRN medication was not always in stock and was not always given as prescribed. We found people did not always have PRN protocols, or if they were in place they were very generic and did not give sufficient detail to determine when to give PRN medication or explain how people presented when they were in pain or agitated.

One person had been discharged from hospital for end of life care and had been prescribed medication on discharge to be given as and when required to ensure they were pain free and comfortable in the final days of their life. These medications were in the home but no protocols were in place to direct staff when they would be required and how they would be administered. Staff we spoke with were not aware the person had been discharged for end of life care. Many staff still thought the person was in the home for respite care, as they had stayed at the home before for periods of respite. Therefore there was nothing in place to ensure

staff could meet this person's needs.

Staff told us people who were prescribed these medications were not always able to tell staff when they were in pain or distressed due to their capacity limitations. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs they may present with to determine when it was required.

We found on occasions people did not receive medication as prescribed. For example we found one person was prescribed an anti-depressant to help with their mood and agitation. The MAR showed the person had refused the medication on three occasions out of four doses which should have been administered. We also noted the MAR described the medication as 15mg when actually the label on the box said 30mg. We sought advice from the pharmacist specialist about how this would impact on the person mental health. They told us that the medication was needed to be consistently administered to have the desired results. If not given as prescribed the person may suffer withdrawal symptoms which could lead to deterioration in their mental health. This person was also prescribed pain relief and medication for constipation which was consistently refused. Staff had not sought advice from the persons GP or determined if a best interest decision should be considered.

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

We found the service had policies and procedures to manage risks. There were emergency plans in place to ensure people's safety in the event of a fire or other emergency at the home. We saw there was a fire risk assessment which had been agreed with the fire safety officer.

However, we looked at the care records for one person and they had a falls risk assessment which identified them as high risk of falls. We saw that there was no care plan to manage this risk. We saw on the falls log that they had fallen on 17 May 2016 in the garden and sustained an injury to their head which resulted in the person being taken to hospital. We saw a 24 hour fall/observation record had been completed. While at hospital the person was diagnosed as having a UTI which had not been identified at the home. The person later returned with a course of anti-biotics. They had another fall on 20 May 2016 when the person was found on the floor. We saw evidence in the daily notes that they were extremely unsettled for long periods throughout June 2016. Several references were made to the person being out in the garden for long periods and being uncooperative. Entries on 22 and 23 June indicated that they were leaning to one side when walking which could have resulted in further falls occurring. We were unable to confirm that this person was referred to the falls team for assessment.

We looked at another person's records who was cared for in bed. We saw a care plan for mobility which stated that the aim of the care was to keep the person 'comfortable and free from sores and infection'. The care plan was not dated and had not been evaluated. We saw there were turn charts in place. On the 17 July 2016 the turn charts stated that redness was noted on their left hip. This information was repeated every day through to the 21 July 2016. However, there was no evidence of a Waterlow risk assessment (gives an estimated risk for the development of a pressure sore) being completed or that the information had been passed for the attention of the district nursing service. The Barthel dependency scale (used to measure performance in activities of daily living) had not been reviewed since 23 March 2016. The assessment indicated the person was fully mobile and presented no risk of pressure sores, when clearly their needs had changed to being at very high risk. This meant that their care needs had changed but had not been updated and measures were not put in place to ensure they received appropriate care and treatment.

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

The staff we spoke with were knowledgeable on safeguarding and whistle blowing policies and procedures. Whistleblowing is one way in which a staff member can report suspected wrong doing at work, by telling someone they trust about their concerns. Staff told us they would not hesitate to report any safeguarding concerns. They told us if they felt the management of the home did not respond appropriately they would report to the local authority. However staff were not following procedures as during this inspection we identified safeguarding concerns that had not been identified or reported by the staff. We made two referrals to Doncaster safeguarding following the completion of the inspection.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the community psychiatric nurse who told us that they had recently made a referral to safeguarding. This was in relation to a person who had been administered medication that had been discontinued but remained at the home awaiting collection from the chemist. They told us that this error was made because the communication between the care team managers was not effective. We were not informed of the outcome of the safeguarding investigation at the time of this inspection.

We looked around the home and found some areas required deep cleaning to eliminate the malodours mainly in the Croft unit and in several bedrooms. We also found the flooring in one of the toilets on the Croft unit was badly stained and needed replacing. Some chairs were dirty and needed replacing as they were not able to be cleaned effectively. The medication store needed refurbishment to make sure medications were stored safely. Staff were seen to be wearing jewellery such as stoned rings bracelets and watches and had painted fingernails which is not following good hand hygiene practices. We saw white overalls were hung outside the entrance to the kitchen. Staff wore these when entering the kitchen. We noted that most were dirty and had tears which meant they were not fit for purpose.

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

Staff we spoke with explained their recruitment process. They said they could not start work until they had received references and a satisfactory Disclosure and Barring Service (DBS) check. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. Files we checked confirmed this.

Inadequate

Is the service effective?

Our findings

People who used the service and the relatives we spoke with told us that the care provided was not as good as they would have expected. One relative told us that sometimes communication between staff could be better. The relative went on to say that they thought standards had fallen over the last few months. We discussed this with the regional care director who told us they appreciated the comments being made and hoped that the new manager would be able to address some of the concerns that they had raised.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We saw evidence that DoLS applications had been submitted to the local supervisory body although most were still waiting for a response.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person's DoLS authorisation had been renewed following a change of home.

We saw in care files that capacity assessment and best interest decisions were included. However, most had not been fully completed to be able to determine if the decision was being made in their best interests.

One person was constantly refusing to take essential medication to help with depression and agitation. We observed this person throughout the inspection and they presented extremely agitated and challenging. We observed the person shouting and swearing at other people that used the service. Some conversations were quite threatening. There was no advice sought from the persons GP or consideration of a best interest decision to determine if it was appropriate to administer the medication in a different way. On the third day of the inspection the care team manager told us that she had obtained verbal best interest agreement from the persons relative, GP and community psychiatric nurse to support the medication to be administered covertly (hidden in food or drink). This had not been identified until we raised it as a concern to the regional care director.

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

People were not always supported to eat and drink sufficient amounts to maintain a balanced diet or adequate hydration. We observed staff did not regularly check people cared for in their rooms to ensure they were offered hydration. The weather was very hot at the time of our inspection and therefore people could

be perspiring and requiring more fluids than usual. We visited one person regularly during our inspection on each visit the person wanted a drink and had very dry lips. The person took a few sips of water each time we visited them. Staff told us they had been requested to visit the person every 30 minutes but found this very difficult as they had other people's needs to also meet.

We looked at food and fluid charts for people. They were stored with the daily notes in a file separate to the main file. We noted that three people were being cared for in bed however the food and fluid charts were not with them in their bedroom. This meant staff could not record accurately at the time that drinks and food was offered. The staff told us that they wrote the records at the end of the shift and jotted down what they had given to people on a scrap of paper. When we raised this during our inspection the charts were moved to the three people's bedroom so that they could be completed throughout the day and not just at handover. When we returned on the second day of the inspection the charts had been moved to people's bedrooms.

People's care plans we looked at identified they were at risk of poor nutritional intake and poor hydration. We found these risks were not managed safely. For example one person was not given any fluids from 7.35am to 10.00am, a period of two hours 25 minutes on 21 July 2016. It was recorded at 10am that they had taken a sip of fluid and at 10.50 had taken 2 sips. When we visited the person in their room at 11.30 they told us they wanted a drink, which they took and also asked for some food. They had not eaten since the evening meal on 20 July 2016. We saw on the care plan for eating and drinking that this person should be supported with this assessed need until a speech and language (SALT) assessment had been completed. The care plan was not dated and there were no record of this care need being evaluated. The multi-disciplinary notes dated from 22 June 2016 to 18 July 2016 showed no evidence to confirm the person had been seen by SALT's. The fluid charts that we looked at did not state the daily recommended fluid intake. However, we saw from the records the person's fluid intake ranged from 175mls to 730mls. We could not confirm if these amounts were sufficient to meet their hydration needs.

The current best practice guidance for hospitals and healthcare services from the national patient safety agency states that, although there is no agreed recommended daily intake level for water in the UK, a conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day.

We visited one person who was being cared for in bed. The room was extremely hot and there was no fan in situ. We raised this with the regional care director who agreed to place a fan to try to reduce the room temperature. We noted there was a full jug of juice and a full beaker of juice on a shelf. The care team manager entered the room as we was leaving the room and was in the process of refreshing the jugs of juice. We saw a new fresh jug and beaker replaced the unused drink. The person was unable to access the drinks themselves and the care manager did not offer the person a drink. As the removed jug and beaker were still full and staff refreshing the drinks did not offer the person a drink we concluded that the person had not actually had any of the previous fluids as they were not offered. This information was fed back to the regional care director who requested staff to assist the person to drink and would provide a fan. We returned to the room two hours later and the jug of juice and beaker of juice was still full. When we returned two days later and went back to the bedroom we found the room was still extremely hot and the room still did not have not fan. A fan was found and placed in the room later during the morning.

We looked at people's food and fluid charts and found these were not completed and people's intake was not clearly documented. It was therefore not possible to determine if people had received adequate food and hydration. For example, for one person on 17 July it was recorded that they had been offered fluids at 10am and 11am but then nothing until 5pm and then there was no further entries until 8am the following day. This did not ensure the person received adequate hydration.

We carried out a SOFI observation of breakfast and lunch on the Croft unit on the first day of this inspection. From our observations we found the mealtime experience for people was poor. For example, we saw people were served their meal at dining tables that were not set for the meal. People were brought a hot drink and thick porridge for breakfast. People were then offered toast. We heard one person ask two care workers to put butter on their toast. The carers said, "It had butter on but it had soaked in." they then carried on with assisting others. The person gave up and pushed the toast away saying, "It is awful without butter." The lunch meal was no better. Tables were again not set and people were served their meal followed by a drink. People were left without support and staff did not offer any alternative when some of the meals were returned uneaten.

We observed lunch on Willow unit on the third day of this inspection. The service of the meal was task orientated and not person centred. There was no menu available in the dining room and no picture menus were available for people to be able to see what was on offer for the meal. Pictures are particularly helpful for people who are living with dementia to be able to make better choices. People were given a choice of meal which was either lasagne or quiche, however, both meals were served with carrots, peas and gravy. People were not given a choice of veg or if they wanted gravy. One person said, "I don't like veg, a side salad would have been nice, I like salad."

The meal time experience was not conducive to an enjoyable experience for people. We saw staff assisting people to eat while balancing their own meal on their lap and eating it while trying to assist the person. This was not person centred and while the staff member was eating they were unable to engage with the person.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified that no staff had received regular supervision in line with the provider's policies. The regional care director told us staff should receive supervision every two months. Most staff had not received supervision since January 2016. Some staff had received a recent yearly appraisal. A member of staff told us that the care team managers were meant to carry out supervisions, but as they were always included in the numbers it was impossible to carry out supervisions so they were not up to date. This did not ensure staff were supported and able to do the job they were employed to do.

Staff told us they had an induction and then were meant to have regular supervisions. However, this was not always taking place. One staff file we checked showed they had commenced employment in October 2015, yet the induction was not completed and no supervisions had been completed. This meant the member of staff was not adequately supervised to ensure they were competent. It also did not give the member of staff opportunity to raise any concerns or questions.

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

Inadequate

Is the service caring?

Our findings

We spoke with people who used the service and their relatives about the care they received. Most of the relatives we spoke with told us that they thought staff did their 'best' to care for their family members. However, several relatives said they felt the care had deteriorated over recent months. One relative said, "You can never find staff to ask how their [family member] was keeping." Another relative said, "This used to be a lovely home but things are not very good now. I am considering if it's the right place for my [relative]."

We saw care staff had very limited time to spend engaging with people in a social way because they were busy carrying out physical care. One relative commented, "People just sit around all day, they have nothing to occupy their time." Some people's rooms were personalised with their own belongings, such as photographs. Other bedrooms were very untidy and not very personalised.

During our visit we spent time in communal areas observing people who used the service and talking to relatives and staff. We saw some positive interactions between people and staff. However, a lot of the time staff were not in communal areas and people were left unsupported by staff. We observed one person very distressed as they had wanted to wash up but told us they were not allowed. We talked to this person and they said, "I want to do something, why can't I do something." Staff did not assist this person or give them something to do to alleviate their anxiety and distress. This demonstrated that some staff lacked compassion and an understanding of how to communicate with people who had complex needs.

We observed one person living with dementia who was picking at the pattern on the carpet. Several staff passed by without offering any support or meaningful activity to distract or occupy them. We saw another person sat in the lounge in their nightwear. Staff offered to take them back to their bedroom but when they refused the staff returned to their next task. They did not spend time encouraging them to return to their room. Another person was in their nightclothes for the whole day and there was little interaction from staff to encourage them to get dressed.

We sat and observed care being delivered in the Croft unit on the second day of the inspection. The atmosphere was tense and a number of people were agitated and this resulted in people shouting at each other. Staff did not intervene as they seemed to lack the skills and competencies to communicate and defuse conflict or manage the complex needs of people. There were no meaningful activities for people using the service to distract them from or manage negative behaviours.

We found people who were cared for at the end of their lives did not have their needs clearly documented. This meant staff were not aware of their preferences or choices and staff did not know how to manage any changes to their care needs. Staff did not regularly check on people who were at end of life to ensure they were comfortable. For example to ensure the people had adequate to drink, were pain free and received the appropriate care to meet their needs and ensure they were comfortable.

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

Inadequate

Is the service responsive?

Our findings

People and relatives we spoke with told us that activities in the home were poor. During this inspection over the three days we saw people were not stimulated. Interactions with staff were limited to care tasks and we saw friction and agitation between people who used the service. Relatives we spoke with told us that when they had visited there were no activities taking place. Social events take place monthly when an outside entertainer visits. We asked to see records that showed when activities were offered to people. These records could not be found. The care team manager and the care staff told us that they were expected to provide activities during their shift but this never happened as they were always too busy.

We checked care records belonging to five people who were using the service at the time of the inspection. We found that care plans did not always have sufficient detail or set out how staff should support each person so that their individual needs were met. For example, one person's care plan for during the night stated that they would sometimes get lost while looking for the toilet staff were to guide them back to their bedroom. The care plan also stated that the person can 'get very angry' and directed staff to report any incidents to the manager and complete behaviour charts. The night care plan had been evaluated monthly but only referred to placing a commode in the bedroom. There was no reference to the person becoming 'angry'. Daily observation notes stated frequent episodes of agitation and aggression. Behaviour charts had not been completed since 6 June 2016. This meant staff were not following the instruction in the care plan to meet this need in monitoring and managing any negative behaviours.

We looked at people's care plans and found their needs were not always addressed and health care services not used when needs changed. For example we found one person was at end of life but the care plan did not reflect this. We found information in the care plan that had not been updated since October 2015. The information in the care file was contradictory and it was not clear how to meet the person's needs. Staff we spoke with were not clear if the person was end of life care or in for respite. One staff member told us the person had got out of bed the day before, they said, "They were not good on their feet I think they should need to use a hoist". We saw the moving and handling care plan stated to be nursed in bed and had not been reviewed. Staff also told us that if they got this person out of bed it should be for only one hour, when they had got out of bed on 19 July the records showed they had been up for three hours. Staff told us, "They had a red bottom when we put them back to bed." Staff we spoke with did not know how to meet the care needs of the person, the care plan was not up to date, reviewed or completed to ensure they received effective safe care. This person also had been assessed as at risk of choking and the care records said; 'waiting speech and language therapist (SALT) referral' there was no evidence in the plan that this had taken place. Staff we spoke with were not aware this had occurred. Therefore the person's needs were not being met.

Health care professional we spoke with told us they found staff did not always follow advice they gave to ensure people's needs were met. For example one professional told us they had explained to staff on a number of occasions the importance of completing monitoring charts so when they visited they could review these to determine any change in needs. They told us these were still not being completed.

Another health professional supporting a person with their mental health needs told us that they had asked staff to record the person's behaviours on a chart. This would help to identify any triggers that may have led to the person displaying behaviours that may challenge others. We saw the last chart was completed on 6 June 2016. However, it was clear from the daily records that the person had frequent episodes of displaying agitation which led to aggression. This lack of recording made it difficult to assess triggers that had resulted in the person displaying behaviours that challenged others. The health professional said that they had raised this with the managers and care team managers but this had not made things better.

We received information that a person on the Croft unit may have been pulled out of bed onto the crash mat. We looked at this persons care records and found evidence of the person being found on the floor and an accident report had been made. The records did not contain information to confirm how the accident had happened. We were told by staff that the manager had made the decision to move the person from the Croft unit to the Willow unit. However this had not been documented and we found no evidence to support how decisions had been reached or if the person's family had been consulted.

We found care was not person centred and people were at risk of being socially isolated due to spending continuous time in their own rooms with limited interaction. Staff were instructed to ensure one person who was cared for in bed was offered drinks at 30 minute intervals. We overheard two staff stating they just did not have the time to meet this need.

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

There was information about how to make complaints available in the communal area of the home, and relatives we spoke with told us they would feel confident in making a complaint should they feel the need to. One relative told us about a complaint that they had raised. They said they felt that it had not been resolved to their satisfaction. This had left them feeling that their views had not been listened to or acted upon. We looked at a record of one complaint which a relative had raised about staffing levels. The record showed no evidence how the complaint had been investigated. The record indicated that the staff member completing the form had 'informed operations manager'. The lack of detail on the form meant we could not determine how the complaint was addressed. There was no date to establish if the complaint had been investigated in the timescales agreed within the provider's policy. We spoke with the relative who made the complaint and they told us that staffing levels remained a concern to them. They felt their concerns were not being taken seriously.

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

Inadequate

Is the service well-led?

Our findings

The service was not well led. There was a manager who had only been in post for three weeks prior to the inspection. We were informed on 26 July 2016 that the manager had received their registration with the Care Quality Commission. However this registered manager also managed another Runwood Homes Limited service in Doncaster so would be dividing their time between the two services. This service did not have a deputy manager to share the management duties with. During this inspection the manager was on leave and the regional care director was at the service and assisted with the inspection. We saw personnel from other Runwood homes in Doncaster were also at the service assisting with quality audits that had not been completed recently.

The tissue viability nurse and the community psychiatric nurse that we spoke with also said that they thought the care at the home had deteriorated. They said communication was not good and this often led to people not receiving the care that met their needs. A visiting social worker told us that they had been involved with the service for many years, placing lots of people in the home. They told us that they were "shocked" when they visited the home recently as they described the home as chaotic and described the atmosphere as tense and unwelcoming.

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

People, staff and relatives we spoke with told us that they thought the care had deteriorated over recent months. Throughout the inspection the atmosphere within the home was tense. Staff were extremely busy trying to meet people's needs. Health professionals and a social worker all told us that they felt communication was poor and "Things were not being passed on" which made them anxious about the care being provided. For example, the tissue viability nurse described two separate occasions one quite recently where they had requested completed documentation for evidence of pressure area repositioning. This could not be found. The second occasion the record was incomplete "hit and miss" from staff. Date and times were missing. "Very poor documentation." They told us they had brought this to the attention of staff. However, during our inspection we still found documentation was not completed fully and was not effective.

All care staff we spoke with told us morale was very low as they felt they were working very short staffed and could not meet people's needs. They felt they were not supported and information was not communicated to them. One staff member said, "I don't like what I am seeing, it is not right people are not getting the care they deserve."

The supervision and appraisals of staff were not carried out in line with the providers' policy and procedures. Care team managers and other staff had not received any formal supervision since January 2016 and most staff had not had their annual appraisal. One of the care team managers said, "I am aware that the supervisions are not up to date but we just don't have the time while on duty." We found some of the training was not effective. For example, 14 of the 26 staff had not completed any dementia training and from our observations it was clear that people did not experience good dementia care. Staff we spoke with could

not remember if they had received training to manage behaviours that may challenge others. We were told by the regional care manager that the dementia training included this topic. This meant the training was not effective as staff were not able to put into practice techniques to defuse or distract people who displayed behaviours' that may challenge others. Since the inspection we have been informed that the provider will be delivering dementia awareness training to all staff on 16 August 2016.

We found there were widespread shortfalls across all aspects of the service. For example, we checked the systems in place for auditing medication. There were records showing that checks were carried out weekly by the care team managers. However, the audits had failed to identify errors in relation to medicines management. These included four people's medication that had ran out before the new stock was ordered. Hand written MAR's that were not checked by two staff. Medication store room consistently recorded as being over the recommended temperature for storing medicines. Patches used for the management of pain not being applied at the correct frequency.

We carried out a check of care records, and found that they contained errors and omissions which had not been identified by means of any effective monitoring system. For example one care plan for a person who used the service for respite had not been updated to include an end of life care plan. We were consistently told by staff that this person's care needs had changed. Several care plans had food and fluid charts within them. However these were not consistently filled in by staff at the time the food and fluid had been given. Staff told us they completed the chart at the end of the shift. We saw large gaps in the records which made it difficult to know if people had received sufficient food and fluid to meet their needs.

One the first day of the inspection a care team manager from another Runwood service had been asked to complete a care plan audit of all care plans. We looked at the care plan audit completed for 17 people who used the service and there were important omissions on each of them. For example, ten of the audits required the MUST (malnutrition universal screening tool) to be completed. Eight people required the falls risk assessment to be reviewed or updated, and eight moving and handling risk assessments needed to be reviewed.

We carried out a check of incidents and accidents at the home. We found there were high levels of accidents recorded from 23 April 2016 to the date of the inspection there were a total of 39 recorded accidents with the majority having occurred in the croft unit. There was no analysis of the incidents and accidents to identify common themes so that improvements could be made. Most were un-witnessed and this supported our concern that there was not sufficient numbers of staff to adequately supervise people to ensure they were safe.

We looked at minutes from meetings held and found some issues raised by staff on 6 July 2016 had not been actioned. For example, staff raised an issue with the pagers which were used to show where people required assistance. When we commenced the inspection on 18 July 2016 we found only one pager that worked intermittently. We asked the regional care director why each member of staff did not have a pager. They told us they were broken. This showed staff raising this were not listened to as no one had addressed the issue. At the same meeting the manager raised an issue that the care team managers were not able to complete audits on care plans due to covering care tasks. This had not been actioned as we found several care plans that required updating.

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

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of response in updating people's individualised needs and risks in their care plans and records that would help staff to monitor people's health and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to act appropriately where incidents of abuse or suspected abuse were identified. Regulation 13(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not have suitable arrangement to ensure people who used the service had sufficient to eat and drink to meet their needs Regualtion 14 (1)(2)(b)