Care Quality Commission

Leopold Nursing Home Limited

Leopold Nursing Home

Inspection report

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Ratings

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

Overall summary

Leopold Nursing Home provides accommodation, nursing and personal care for up to 32 older people, some people are living with dementia.

There were 24 people living in the service when we inspected on 12 January 2015. This was an unannounced 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.

Our previous inspection of 22 August 2014 found that improvements were needed relating to the care and welfare of people and the recruitment procedures and processes of staff. The provider wrote to us to tell us how they had addressed these shortfalls. During this

Summary of findings

inspection we found that improvements had been made in staff recruitment but whilst some areas relating to care and welfare of people had improved, other serious concerns were identified.

We found multiple breaches of regulation that affected the well-being of people using the service. People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Risks to their welfare were recognised but assessments for people were not up to date or in some cases completed. People's nutritional needs were not being consistently assessed and met. Staff did not know enough about people or the care they needed to ensure that they received consistent and safe care at all times.

There were appropriate arrangements in place to ensure people's medicines were stored safely. People were not provided with their prescribed creams when they needed them and in a safe manner.

There were not sufficient numbers of staff to meet people's needs. Staff were not always available when people needed assistance, care and support.

People were supported by staff who had not been provided with the support and training to ensure that they had the necessary skills to meet people's needs effectively. Staff did not always have training which were reflective of people's needs, including dementia, mental health and diabetes. In addition staff did not have the skills to manage situations where people they cared for became aggressive. This made them and others feel unsafe.

People's privacy and dignity was not always respected and staff did not always interact with people in a caring manner.

Despite staff having training in the Mental Capacity Act 2005 and not all understood how this impacted on the care provided to people. The systems in place to obtain and act in accordance with people's consent were not robust so we were not assured that people's choices and rights were being respected.

People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment. Health and social care professionals confirmed this but also expressed concern about the standard of care provided.

The service was not run in the best interests of people using it because their views and experiences were not sought enough. Improvements were needed in the ways that the service obtained people's views and used these to improve the service.

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 consistently safe.

Systems to keep people safe were not robust and effective. Risks to people's welfare were not always fully assessed and therefore the care delivered was not always consistent or effective?

There were not enough staff to meet people's needs.

People were not provided with their prescribed creams when they needed them and in a safe manner.

Is the service effective?

Inadequate

The service was not consistently effective.

Staff were not trained to meet the needs of the people who used the service.

The Deprivation of Liberty Safeguards (DoLS) were implemented when required. However, despite receiving training not all staff understood the DoLS and Mental Capacity Act (MCA) 2005. Systems in place to obtain and act on people's consent were not robust.

People's nutritional needs were not being consistently assessed and met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always interact with people in a caring manner. People's privacy and dignity was not promoted and respected.

People and their relatives were involved in making some decisions about their care.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People's wellbeing and social inclusion was not assessed, planned and delivered to ensure their social needs were being met.

People's concerns and complaints were investigated and responded to.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The service did not provide an open culture which was empowering. People were asked for their views about the service and their comments were listened to, however they were not used to improve the service.

Summary of findings

The service had a quality assurance system, but this was not robust enough to identify shortfalls. The provider did not ensure that people received a good quality service at all times.

Leopold Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection took place on 12 January 2015 and was unannounced.

The inspection team consisted of two Inspectors and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service. The Expert by Experience had experience of older people and people living with dementia.

We reviewed the previous inspection reports to help us plan what areas we were going to focus on during our inspection. We looked at other information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with 13 people who were able to verbally express their views about the service and five people's relatives. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to eight people's care. We spoke with eight members of staff, including the registered manager, the nurse on duty, care staff, catering and domestic staff. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service. We also spoke with stakeholders, including a member of the local authority safeguarding team and three health care professionals.

Prior to our inspection we had received concerns about the service provided; these had been reported to and investigated by the local authority. The local authority had kept us updated with the support that they were providing to the service to assist them to improve the care and support provided to people. During our inspection we looked to see what action had been taken as a result of these concerns.

Inadequate

Is the service safe?

Our findings

People's needs were not consistently met by sufficient staff numbers. People told us that they felt that there were not enough staff to meet their needs and that their call bells were not answered promptly. One person said, "There are not enough staff. The staff are always busy. I cannot mobilise safely on my own to the bathroom and so I press my buzzer for staff to come and help me. I can wait over 30 minutes for staff to get to me. Sometimes I have to sit on the toilet for a long time waiting for staff to come and get me." Another person commented, "They leave you here [in their bedroom] and go away. I have been ringing for half an hour and they have not come and when they come in they turn it off and go away." Another person said, "There are not enough staff for the residents, not with the amount of care some of them need." Another person told us about the call bell response times, "Sometimes it takes 20 to 30 minutes or longer but usually they are quite good. It is when they are busy with lunchtimes it is the worst but on the whole it is ok but I would like them to come quicker when I need [to use the toilet]."

One person's relative told us, "Staff are absolutely brilliant and are rushed off their feet and it comes across as under staffing but they always have a smile on their faces and I don't know how they do it. There are quite a few demanding people who cannot wait [to receive support for specific tasks] but staff are taking people to the toilets or hoisting and they cannot drop everything and the staff are verbally abused by them."

There were not enough staff to provide the assistance that people wanted and needed to meet their needs. For example, one person was being supported on a one to one basis by a staff member, they were participating in a bingo activity with others in the service. Another person asked for assistance and there was no other staff member available to assist them so this member of staff had to leave the person in the middle of a game. The person was looking around and did not complete their activity until the staff member returned.

Staff responses to people who required assistance varied. Some people were left sitting in wheelchairs at a dining table for long periods of time, for example we saw that one person was sitting at the table from 11.45am at lunchtime and was not helped to move until 1.55pm. We saw that people were not supported in a timely manner to reduce the risks of discomfort. One person asked to use the toilet at 1.05pm and was not assisted until 40 minutes later. When they were being assisted another person asked for help to use the toilet, this was not provided until 15 minutes later. A staff member told them, "You can when (first person's name) has finished." This interaction did not respect the first person's privacy and dignity. Call bells were not answered in a timely manner and on one occasion we monitored one ringing for 25 minutes before staff responded.

Staff told us that they felt that there were not enough staff to make sure that people were supported in a safe manner. They said that people sometimes had to wait a long time to be seen due to the lack of staff. One staff member said, "Challenging behaviours have a huge impact on the staffing levels and they need more staff including moral support."

The registered manager did not have a formal way of calculating people's dependency levels to assess how many staff were needed. Without this system they could not be assured that there were enough staff to meet people's assessed needs. The registered manager and staff told us that there were problems with staffing when someone telephoned in sick and they could not get cover. The registered manager gave us a recent example where the staff team on duty was significantly reduced because of sickness on a Sunday. We asked how they managed when this happened. Their reply was that staff's workload was increased. There was no documentation provided to show how the service had planned for when there was staff sickness or short notice absences. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Administration records, kept in people's bedrooms, for creams and lotions were not completed appropriately to show they were provided with their prescribed creams when needed. For example one person was prescribed a barrier cream in relation to the risks of pressure ulcers developing, there was nothing recorded on their records to show that this had been administered since November 2014. Their assessment clearly stated they were at high risk but when we asked staff why there was no record of the cream being administered, they did not know and could not confirm if it was being applied as it had been prescribed. There was no guidance for staff in place to show when these creams should be administered and

therefor the service could not assure us that people were receiving all of their medicines when they needed them. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with one person about if they were happy with the arrangements for how they were provided with their medication. They said, "I get my pills regularly and they [staff] give me a drink to take them. I don't think there are any problems."

People's medication was stored securely so it was kept safe but available to people when it was needed.

Risks to people's health and welfare were not detailed enough to ensure people were kept as safe as possible. People's care records did not guide staff with detailed risk assessments which identified how the risks in people's daily living, including the use of mobility equipment, accidents and falls, nutrition and pressure area care and prevention, were minimised. For example, there were charts in people's bedrooms which showed how they were supported to reposition during the night, but these held gaps and some had not been completed for the daytime. The registered manager told us this was because people used the communal areas during the day and they were not in bed. Despite these people being assessed as being at risk we had seen people sitting in arm chairs or wheelchairs all day during our inspection visit and none of these had been assisted to move or reposition throughout the day to minimise the risks of pressure sores developing.

One person, who was cared for in bed, had been assessed as being at risk of developing pressure ulcers and their records stated that they should be repositioned on a two hourly basis. The records from the last five days did not show that this had happened as directed and staff could not confirm if it had been completed either. Another person who was cared for in bed had pressure ulcers and their pressure area risk was scored as high. We reviewed the person's turn charts and found significant gaps. During our visit we observed them over a period of over 6 hours and saw their position had not changed. Another person who was cared for in bed and at high risk of developing pressure ulcers did not have a repositioning chart. The registered manager told us that they did not require one despite them having a recent pressure ulcer and being prescribed barrier cream for a reddened area, which can indicate a further skin breakdown. Another person was identified at being at risk of developing a pressure ulcer. The registered manager told us the person had refused the support offered but there was no instruction for staff to explain how they could best support this person with the risk. For example, the person had not been referred to a tissue viability specialist nurse to help determine any other solutions for their care. This told us that the provider and registered manager did not have robust systems in place to support those with pressure ulcers and to prevent the risks of pressure ulcers developing and to deliver high quality care. Staff were not sure what charts people were on or how regularly they should be checked and monitored. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Our previous inspection of 22 August 2014 found that the provider's recruitment procedures and processes were not robust enough to ensure that the people who used the service were cared for and supported by staff who were able to care for people in a safe manner. During this inspection we found that improvements had been made.

We looked at the recruitment records of four staff members who been employed since our last inspection. Appropriate checks had been made on these staff to make sure that they were suitable to work in care and were of good character. The application form had been reviewed and now explored the reasons for leaving previous employment and the reasons for any periods of unemployment. These improvements meant that there were processes in place to safeguard the people who used the service from being cared for and supported by staff who were not suitable and safe to work in care.

People's views about the service varied. Four people told us that they felt safe living in the service and a further three people told us that they did not. One person said, "Yes, I feel safe and secure." Another commented, "Yes I feel safe, there are people about and I would give it 8 out of 10." Another person said, "I do not feel safe, I want to feel safe," and, "Now it is really bad and the staff are fed up, residents are fed up and I am not safe in my room [because another person had gone into their bedroom]." We discussed the issue of people going into other's bedrooms with the registered manager and were able to see that they were taking action to address this.

Staff who we spoke with understood their responsibilities to ensure that people were protected from abuse. They were able to explain the different types of abuse and if they had any concerns how they would report them. However,

Inadequate

Is the service safe?

not all staff who worked in the service had received training in safeguarding. Therefore we could not be assured that all staff had the same level of knowledge as those we had spoken with. The local authority were providing the service with support to improve the service and had identified safeguarding concerns. These had not been independently identified and reported by the management in the service.

Staff had received training in moving and handling, including using equipment to assist people to mobilise. We saw staff on two occasions assisting people to mobilise into an arm chair using hoist equipment. Although this was done safely and efficiently, there was no interaction from the two staff members who were assisting the people. Without this interaction staff could not check if people felt safe and secure or if they were experiencing pain or discomfort. The local authority had been supporting the service in developing moving and handling risk assessments and had held workshops to support the staff to meet people's mobility needs safely. Despite this professionals still reported poor practice on some occasions.

We also saw some practice that was unsafe and could have caused injury to both the person and the staff member. Staff did not have the skills to assist this person in a way that protected the person and themselves. We fed this back to the registered manager to enable them to take action to improve this.

We looked around the service and found that it was free of obstacles which could cause a risk to people using the service and others. Risks to people injuring themselves or others were limited because equipment, including the passenger lifts, fire safety equipment and hoists had been serviced so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire. There was a legionella risk assessment in place and a designated person (maintenance person) allocated as responsible for legionella testing to make sure that the risks of legionella bacteria in the water system was minimised.

The service had a business continuity plan. This covered what the procedure was in case of fire or the need to evacuate people. The provider had a mutual agreement with another of the provider's services. The registered manager told us that if there were any interruptions to the service, such as flooding and loss of utilities, then people would be transferred to this service.

Inadequate

Is the service effective?

Our findings

Staff were not provided with the training that they needed to effectively meet the needs of the people who used the service. We tracked the personnel records of four staff who had been recruited in between September and November 2014. None had received training in safeguarding adults from abuse or had an effective induction programme which provided them with the information that they needed to ensure that people who used the service were protected from abuse. Only six staff had received safeguarding training in 2014. Another nine staff had received the training prior to this. This meant that the opportunities for staff to refresh and update their knowledge were not in place. We were concerned about this area of training specifically because the registered manager and local authority had reported to us a number of concerns which related to keeping people safe from harm. The registered manager said that staff were told about this in their induction and the local authority were providing safeguarding training to the staff team.

Some people required support with behaviours that may be challenging to others or distress reactions, associated with dementia. These people's care plans did not provide detailed information about how staff were to support them effectively to ensure that they and others were safe. At our previous inspection of 22 August 2014 the registered manager had told us that the staff were going to be provided with training in this area following an incident that was investigated by the local authority. However, the staff had not yet been provided with this training even though it had been identified as being needed over four months previously. The registered manager told us that the training was planned but could not tell us why it was taking so long to introduce.

We observed that staff did not have the skills to appropriately support people with their distress and actions that had a negative impact on others in the service. For example, a person told us that they were kept awake by a person who called out during the night as staff were unable to help them settle. We saw a person who was verbally abusive to staff on several occasions throughout our inspection. Staff did not have the skills to assist them effectively so that they might be diverted or supported to be calmer. At one point we saw three staff speaking with this person at the same time, disagreeing with what they said, which increased the person's anxiety. This had an impact on the others who showed signs of distress and worry. There was no structure in how the staff supported them after the incident.

One person told us that the behaviours of others in the service were impacting on their and other people's wellbeing. They said, "The staff try their best, but when they are dealing with them [other people] it is taking the time away from the rest of us." A staff member told us, "Training for the staff on physical aggression would be useful."

Many people using the service had a dementia related illness. The staff had limited knowledge about dementia care and they were unable to tell us about different types of dementia or how it progressed. It was evident that staff did not have effective dementia awareness which might help them to care and support people. Not all staff had not been provided with training in dementia and we saw that they were unable to engage some people effectively so that they were involved with their surroundings and everyday lives. They did not recognise when people were showing signs of being disengaged, for example staring ahead with no interaction from staff. Because staff did not understand how dementia affected each individual person they were unable to approach their care in a way that supported them as much as possible.

There was no formal training provided on people's specific needs including mental health conditions and diabetes. Only five staff had received training in pressure ulcer prevention in 2014 despite this being a condition that people were are risk of developing. There was an induction in place which included new staff shadowing experienced staff and being shown how to perform care tasks, but this did not include formal training or checks to ensure competency.

We saw that staff were provided with one to one supervision meetings, these and staff meeting minutes did not show that staff concerns were listened to and addressed. Staff who had previously been suspended were not provided with one to one meetings to discuss issues and to provide support when they returned to work. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans identified if people had the capacity or not. However, they did not guide staff on actions they should take if a person lacked capacity to make specific

decisions. The registered manager told us staff gained consent when they needed to and sought guidance from others in order to make decisions in their best interests. But this was not detailed in people's care plans. Written consent had not been sought for people's care, treatment and support other than for the use of bed rails. There was no explanation in people's records as to why this consent had not been sought. Without this staff could not tell us that they were ensuring people's consent was being sought and respected.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty DoLS which applies to care homes. Staff had been provided with training in moving and handling, fire safety, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager and one staff member had an understanding of DoLS legislation. The registered manager told us that they had completed referrals to the local authority in accordance with new guidance to ensure that any restrictions on people, for their safety, were lawful. One staff member and the registered manager understood the MCA and were able to speak about their responsibilities relating to this. Other staff had minimal, if any, knowledge about mental capacity and what this meant to people or them as staff. Without this knowledge it is difficult to show that people are provided with choice as far as possible and that 'best interest' decisions were only taken when appropriately assessed and agreed.

We saw one person who said that they wanted to leave the building. The actions from one staff member did not support this person in a way which respected their freedom to make their own decisions. We discussed this with the registered manager, who had not independently identified this as an issue, and they told us that they would consider if a DoLS referral was needed and that they would discuss this further with the person's social worker. Following our visit, we shared our concerns with the local authority, which we had told the registered manager we were going to do.

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

People's views about the food that they were provided with varied. One person said, "The food varies, they said it was mousse but it was a cheese cake topping. I was offered macaroni cheese but it was just plain pasta. One cook is good and the other is really bad and at Christmas the sprouts were grey, the gravy fluorescent and there were no potatoes at all." Another person commented, "I didn't enjoy my lunch. I keep asking for milk but haven't got any." Another person commented, "I only ate the soft bits of the fishcakes, I have dentures so cannot manage the outsides and had ice cream for sweet." The staff had not identified this as an issue and took action to provide food that was cooked in a way that the person could eat it.

We saw that people were offered with choices of drinks and snacks throughout the day of our visit. However at tea time, people complained that the sandwiches were dry. There was a selection of cold drinks in the dining area, but these were not easily accessible to people if they wanted to get themselves a drink. People would have to reach across a table and chair to reach them.

We saw that where people required assistance to eat and drink, this was done at their own pace and in a calm way. However, some people did not eat their meal and this was just taken away, with little or no verbal encouragement to eat. People who chose to eat in their bedrooms were not provided with the support they needed, for example one person who was in bed was lying in bed whilst attempting to eat. We saw that they struggled to get their food into their mouth. Their food fell on to their clothes and in the bed. We highlighted this to the registered manager who told us that the person preferred to maintain their independence but they would look into it. We saw another person was struggling to swallow their food. Staff had not identified that the person was struggling and did not offer any assistance.

People's daily records identified that percentage of people's meals that they had eaten, but there was no indication of the size of the portions to allow staff to accurately identify the amounts people had eaten. Records showed that people were weighed regularly and that when there had been issues, such as weight loss, the staff had sought support and guidance from a dietician. However, one of the people's care plans we reviewed stated that they were at risk of malnutrition and there was no detailed risk assessment in place to show how these risks were minimised. This is a breach of Regulation 9 of the Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were also positive comments received from people regarding the food in the service but these were not consistent. One person said that they had porridge for breakfast, "Just how I like it." Another said, "It is lovely food

Inadequate

Is the service effective?

here." Another person commented, "I have enough food, I have a small appetite and they always give me an alternative. There is always a choice of two and I have never been hungry here."

People's relatives were positive about the food in the service. One said, "[Person] likes the food here." Another told us, "Every day I come and have lunch with my [person] and the food is very good."

We spoke with the chef who knew about the specific dietary requirements of people. They were able to show us a chart of those people who needed food fortification and supplements. We saw that people were provided with milkshakes and were encouraged to drink them, these are to assist people to receive a nutritious diet and maintain a healthy diet.

People said that their health needs were met and where they required the support of healthcare professionals, this was provided. One person said, "They [staff] get someone in pretty sharpish if you are not well." One person's relative told us about how their relative was provided with access to health professionals when needed. They said, "It is very good and my relative is waiting for a meeting with the dementia team but they are looking after [person] well and the quality of the care is good," and "In consultation with us they [staff] called the doctor and he prescribed some meds [medicines] to help [person] sleep."

People had access to healthcare services and received ongoing healthcare support. Staff took action to seek support and guidance when issues with people's health were identified.

Requires Improvement

Is the service caring?

Our findings

People's comments about staff were varied and they had different experiences that affected their view about if staff treated them with care and compassion. One person said, "Some are fine." Another commented, "I have been here a long time but I am better now and I am now walking with a frame and the staff take care of me." Another person said, "I know everyone here and they look after me very well." However, one person said, "They [staff] are unkind and ignore you and just put the bell off [when they used their call bell]." One person's relative told us, "The staff are very good and they are marvellous to me."

There were some positive exchanges between people and those caring for them but this was inconsistent. People's privacy and dignity was not always promoted and respected. Some staff did not interact with people at all unless they were providing task based support, such as using the hoist to assist them to mobilise. We had been chatting and laughing with one person. When the staff arrived to administer their medicines, after the person had taken their tablets from the staff member they told them what we had been talking about. This staff member did not smile and said to the person, "Just have your drink," and left. This interaction was not caring and the person looked at us and said, "Oh well." We told the manager about this and they told us that it would be addressed. We also saw one person receive their medicines in the toilet area. This did not promote the person's dignity and was also not a hygienic area to give medication in. At other times we saw staff give people their food or drinks without speaking with them. This meant that staff were not always showing compassionate or a caring approach. We saw three people at different times using toilets with the door open. On one of these occasions, a member of staff walked past the toilet and did not close the door.

When one person was assisted by a member of staff to go to the toilet, another said as they were passing by, "They have already been." We told the manager about this and they said that there were no restrictions on the amount of times that people were assisted to use the toilet. The dining area smelt strongly of faeces following the lunch time period. Staff attended to a person after we highlighted that they may have become incontinent. This meant that the staff had not noted this and had not been responsive to the person's needs to ensure that they were comfortable and that their dignity was respected.

One person's relative told us that they had raised concerns that their relative was often wet when they visited and needed to be reminded to use the toilet, due to their dementia they may not recognise when they needed to use the toilet. We did not see this person being asked if they needed to use the toilet and their care records did not guide staff to do this to ensure that the person was supported with their continence needs when they needed it. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had been involved in planning their care and support. This included their likes and dislikes and their decisions about end of life care. These detailed people's wishes for the care, treatment and support they wanted at the end of their life. However, there was limited information to show that people's preferences were regularly revisited to ensure that staff were provided with the most up to date information about people's needs and choices.

People's records included information to tell staff about people's life experiences, diverse needs and preference. This included how they communicated, mobilised and their spiritual needs. However, there was limited information about how these needs were met. Where people could not verbally express their experiences to staff there was a 'this is me' booklet in place which identified what was important to the person, their family, their work history and any hobbies and interests they had. However, one of these had not been reviewed or updated since 2012. One person's care records only stated that they preferred to stay in their bedroom and watch television. Staff were not able to tell us about the individual people that they cared for and told us that they would have to ask someone else.

Most people who we spoke with told us that the staff listened to what they said and their views were taken into account when their care was planned and reviewed. One person said, "Some are excellent and they have to do what they are told." Another person said, "I spend the day in my room [bedroom] because I choose to do so." Another person commented, "I get up when I want and I go to bed when I want." This was confirmed in our observations, when they asked to be supported to go to bed this was done by staff. However people's views differed depending

Requires Improvement

Is the service caring?

on how independent they were. For example another person told us that they did not always choose when they wanted to get up in the morning as it depended on staff availability. Staff were made aware of the areas of care that people could attend to independently. We saw staff encourage people's independence at lunch time.

People's relatives told us that they were consulted about their relative's care and that they were kept updated about their wellbeing.

The service had placed CCTV cameras in the communal lounge of the service. The registered manager told us that this was to enable them to observe the activities of the staff. We were shown a document which identified that some people and/or their relatives had been notified of this and had given their verbal consent for this happening. This showed that people were consulted about actions taken in the service that may compromise their privacy. However, there was no written consent in place and no documents given to us to show that people and their relatives had been given written information about what the cameras were for and how they would be used.

Inadequate

Is the service responsive?

Our findings

Our previous inspection of 22 August 2014 found that care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. Staff were not responsive to people's needs. The provider wrote to us and explained the actions that they were taking to address this. During this inspection we found that some improvements had been made, but there were further improvements needed.

The registered manager told us that there was a new care plan in place and they were intending to transfer all care plans to this documentation. One of the eight people's records we looked at held this documentation. We noted from this record that some improvements had been made, but there was still more work to do to show how people's care was assessed, planned for and met. The other records we reviewed did not provide staff with information about people's individualised care needs and how they were to be met.

People had varying views about the care they were provided with. One person said, "There is no point in ringing the buzzer as they [staff] only come sometimes." However another said, "They [staff] are alright and I have got a bell so I can summon them." We saw that one person who was in their bedroom did not have their call bell within their reach; we asked how they called staff if they needed help. They said, "By shouting my head off or throwing my cup." Another person told us that if they were in their bedroom with the door closed, staff would not come to check on their wellbeing and commented, "If your door is closed you never get a coffee, some of the people [staff] don't make sure if you are in here or not."

One person repeatedly called out and pressed their call bell. There was no management plan of how staff should support this person and we saw that they often just ignored the bell and the person calling out. There was no instruction to staff about how they could approach the care for this person which may help them and reduce the amount of times they called. Much of the care they required was reassurance but this had not been explored by staff to see what might help.

People who had asked to be assisted to go outside to [for a specific activity] were responded to promptly, others had to wait, for example to be assisted to go to the toilet. Those who were able to verbalise their needs were supported more quickly than those who were not, or those who were quieter and/or more polite in asking for assistance. This often led to care needs not being met in a timely way which we have described elsewhere in this report.

People's views about how they spent their time including social activities were varied. One person said, "They had a beach ball here once but they do it with the other patients." Another person commented, "I go downstairs to the singing and the music." Another person told us, "We do craft and gentle exercise, other than that I watch television." Staff were unable to show us that people who preferred to stay in their bedrooms were provided with one to one social time to prevent them becoming lonely and isolated. One person said, "I have all my meals in here [bedroom] and I eat and sleep in here and they call that dignity." Another person told us about how other people's behaviours had affected them and said about using in the communal areas, "You cannot sit downstairs quietly, you just cannot get away from it all." One person told us that they worked and another person's relative told us that they took the person out to a weekly day centre. One person's relative told us that they had, "Brought two karaoke DVDs in for them to play so that people could sing along to the music but they have never used them."

The registered manager told us that this year they were having arts and crafts activities for people. There were no items displayed in the communal areas which had been made by people. There were no sensory items in the service which people could handle and use to stimulate their senses, particularly those people who were living with dementia.

During the morning of our inspection we saw that people received no individual or group stimulation, apart from those who had newspapers and visitors. One person was assisted by a member of the care staff throughout the day on a one to one basis. We saw that this person was supported to undertake activities such as looking at photographs and magazines. Staff told us that they usually did an activity with people at 4pm. At this time we saw six people enjoy a game of bingo with staff. During this time there was laughter and light hearted chatter between people and staff. There was no other social stimulation provided for the other people in the service. There was just one staff member who sat down with people and had conversations with them, individually and in groups. In

Inadequate

Is the service responsive?

general people's needs were not planned for, assessed or delivered to ensure that their individual needs were met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives told us that there were no restrictions on the times that people could have visitors. We saw that people's visitors came and went during our visit. This showed that people were supported to maintain relationships with the people who were important to them and reduce their isolation. One person said, "I have always loved being here and my family come in to see me in the evenings."

People told us that they knew who to speak with if they needed to make a complaint. One person commented, "I would tell the staff if I needed to." A relative shared concerns they had raised. We saw that they had been responded to and improvements had been made.

The registered manager produced action plans in relation to complaints and shared these with staff. This helped to reduce the reoccurrence of complaints with a similar theme. There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. People had opportunities to raise concerns. For example minutes of a meeting in November 2014 showed people and their relatives were asked if they had any complaints or concerns. One person told us that they attend meetings, "We had a residents meeting and I went."

Inadequate

Is the service well-led?

Our findings

People's comments varied about the management and leadership of the service. One person said, "The manager is wonderful." However, another person commented, "Staff are all nice, the manager I don't know at all." Another told us that they had told the manager about not being happy with things in the service and said, "I have spoken to the manager to do something about this and she just looks at me with a vague look."

There was a lack of systems in place to demonstrate good leadership and management. Staff described their duties as a list of tasks they needed to do. They did not have adequate knowledge about the people they looked after. When asked about the different people they cared for they all said that they would have to ask someone else. Care staff said that nurses were responsible for people's care and care plans. We asked the deputy manager (a nurse) if any people in the service had any pressure areas and they told us no, yet the registered manager told us that there were. During our observations staff were task led and we did not see evidence that the culture of the service was person-centred and staff were empowered to drive improvement.

There was no clear vision for the staff to ensure that everyone knew what they were working towards. Staff were open that they were struggling. For example one staff member told us "Staff are trying to cope and maybe burnt out a bit and we are all supported by the manger and she is open to our concerns. We discussed transferring difficult residents to one floor, but there are practical difficulties and others do not want to transfer down." They also said that they were having meetings to discuss issues and, "The new challenges are wearing out the staff and the moral decline on them has grown." Staff told us that they did not feel supported and the registered manager was not in the service often enough.

The registered manager was splitting their time between this service and another of the provider's services. Following our visit the registered manager told us that they would not be working in the other service as a manager had been appointed. They felt this would help them to focus on the issues we had identified during our inspection and the ongoing development of the service.

There was a lack of effective auditing and monitoring to ensure the quality of the service. The registered manager told us that the provider had employed the services of a person who was assisting the service with their quality assurance. We asked what they did and they said that they spoke with people who used the service, staff and looked around. We asked if they had action plans which identified how they were planning to address the shortfalls. The registered manager told us that this person did write things down and met with the provider and registered manager. We were not provided with any action plans which showed the plans to improve the service. There were ineffective systems in place to identify, monitor and manage staffing levels, staff training, people's consent, people's dietary needs, medicines and how staff interacted with people in a caring manner which respected their privacy and dignity.

The local authority had told us that they had been supporting the service to improve since our last inspection of 22 August 2014. They told us that they had noted minimal improvement and their recommendations for improvement had not all been acted upon. The local authority had identified that staff at the service needed training to understand more about ensuring people's dignity was being understood and considered. This had not been independently identified by the service's management or provider.

The service's quality assurance systems were not effective in driving continuous improvement, take action to address shortfalls and to use information from incidents, safeguarding and people's comments to improve the service. There were audits in place regarding people's falls, but these had not been analysed to identify patterns and take actions to reduce the risks of incidents re-occurring. This did not help to make sure that people were safe and protected as far as possible form the risk of harm. The registered manager told us that they had put actions in place to help reduce the recurrence of similar events, but we were not provided with action plans to corroborate this or show what had improved.

Surveys were undertaken every six months to seek the views of people. These consisted of five people being asked by staff for their views of the service, which meant the results were not fully representative. The registered manager told us that they sent surveys to people's

Inadequate

Is the service well-led?

representatives when they had passed away. No other ways to obtain people's views had been explored. This meant the provider had missed an opportunity to seek views and make improvements as a result.

The registered manager had undertaken a 'dignity check survey' in June 2014. All of the results were positive. However the survey consisted of eight people only. There was nothing documented as to why those people had been selected and why others were not. There was no reason as to why this survey had not been repeated to see if there were any changes since its completion. Our observations and feedback from other professionals showed that the results were not reflective of the practice of staff we observed.

There were schedules in place which showed when the service was cleaned, but there were no systems in place to identify if this cleaning was effective. The registered manager told us that they audited the hygiene and cleanliness in the service. However, these were not robust enough because we found a number of areas which needed attention to protect people from the risks associated with poor hygiene. We saw that in some bedrooms the carpets were not clean. There was litter underneath people's beds and there was a layer of dust on people's bedframes. Toilets were stained inside and were not clean around the toilet seat hinges. Hand wash basins had dirty plug holes and overflows, some had hair in them, and taps were stained with lime scale. This was a risk to cross contamination. There was an unpleasant odour in the entrance to the service and corridor. This showed that spills that could cause an odour and risk to cross infection were not cleaned effectively. In the laundry there were clean and dirty clothes and linen next to each other. The cleaning mops and buckets were kept next to dirty clothes and linen. The access to the laundry area was not restricted and people who used the service could gain access to this area. There were chemicals subject to Control of Substances Hazardous to Health (COSHH) regulations, stored in the laundry. This meant that people had access to the chemicals and if they were ingested there was an increased risk to their safety and health.

There were disposable paper towels and hand wash liquid in toilets and bathrooms for people to use to limit the risks of cross infection. However, there was no hand washing audit in place to check that staff effectively washed their hands.

The provider regularly visited the service and visit reports were in place. We saw that a different aspect of the service, or a topic such as dignity, had been highlighted each month to be included in the visit. Results from the provider's visits were discussed at staff meetings. However, there were no action plans following the visits to address areas of the service that required improvement. Therefore actions were not monitored within a time scale to demonstrate that improvements had or had not been made.

The provider had failed to identify and take robust action to ensure that a safe, effective, caring, responsive and well-led service was being provided to people. This is a breach of Regulation 10 of the Social Care Act 2008 (Regulated Activities) Regulations 2010. The service's quality assurance systems did not identify, assess and manage risks to the people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services were not protected by the risks associated with the unsafe and management of medicines, by means of making appropriate arrangements for the recording of administration of prescribed creams and ensuring that these are provided to people when they needed them. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services were not supported and cared for by sufficient numbers of staff to meet their needs. Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People who use services were supported by staff that were not trained and had the necessary skills to meet their needs effectively. Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	Staff did not always interact with people in a caring manner and people's privacy and dignity was not promoted and respected. Regulation 17 (1) (a) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Suitable arrangements were not in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided. Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1) (a) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The enforcement action we took:
Warning notice to be compliant by 16 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The service's quality assurance systems did not identify, assess and manage risks to the people who used the service. Regulation 10 (1) (a) (b) (2) (b) (i) (iii) (c) (i) (e) of the Social Care Act 2008 (Regulated Activities) Regulations 2010.

The enforcement action we took:
Warning notice to be compliant by 16 March 2015.