Ideal Carehomes (Kirklees) Limited

Lydgate Lodge

Inspection report

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Ratings

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

Overall summary

The inspection took place on 3 and 7 September 2015 and both days were unannounced. The home was last inspected July 2013 and was found to be non- compliant in the care and welfare of people who use services. A follow up inspection in February 2014 showed the service to be compliant in all areas.

Lydgate Lodge provides care and support for up to 64 older adults. The home has four units, Honeysuckle, Wilton, Oakwell and Blossom. Two of the units provide support for people living with a diagnosis of dementia. Each unit has a communal lounge, a quiet lounge and a dining area.

There are enclosed gardens to the side of the building that can be accessed by people who live in the home.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived at the home and their relatives told us they felt safe living at Lydgate Lodge.

Summary of findings

The staff we spoke with could identify types of abuse and were aware of how to raise concerns about harm or abuse. The safeguarding training for staff was out of date. The registered manager wasn't referring incidents in line with the policy of the service.

We asked people who lived in the home whether there were enough staff. They told us they felt there were not enough staff to respond to their needs in a timely manner. Staff we spoke with also told us they did not feel there were enough staff to meet people's needs. We observed people had to wait long periods of time to receive assistance with their continence.

The home had recruitment and selection system in place which ensured staff had the right skills and knowledge to carry out their role.

However, the service had not invested in staff training to ensure they had the appropriate skills. The training for staff was out of date and staff had not received supervision and appraisals as part of their support. The registered manager told us they had plans in pace to rectify this in the next week.

Staff had a good understanding of the needs of people who used the service. The care records were comprehensive but not person centred. Only one of the people we spoke with had been involved in the development of their care plan.

There was no evidence to show the service provided activities aimed at stimulating people through the day. Staff were expected to organise activities as part of their role.

The dining experience in the four units was varied. On one unit people were not offered a choice of vegetables to accompany their meal food or portion size. On other units, the dining experience was more positive.

The experience of care was varied within the units. On three units we saw staff treated people with respect and dignity. On another unit, staff did not spend time with people and any interaction was brief.

We asked people who used the service about the way they had been treated. They felt staff were very kind and caring.

The registered manager had a presence in the home every day, they also worked the occasional night duty. Staff we spoke with felt supported by the manager.

The manager was not offering staff support through supervision and appraisals. They acknowledged they had not been carrying out appraisals and had put plans in place to address this.

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?

Requires improvement 

The service was not always safe.

People who used the service told us they felt safe living in the home.

Training in safeguarding for staff was out of date.

The registered manager wasn't referring all safeguarding incidents to the local safeguarding team.

The levels of staff were low on the units. People had been left for periods of up to thirty minutes unsupervised.

The registered manager was not using the dependency tool to effectively allocate staff to units.

People who used the service told us they felt safe living in the home.

Medicines were prescribed but not always administered to people appropriately.

Risk assessments were in place

Is the service effective?

Is the service effective?

Requires improvement 

The service was not always effective.

Staff did not receive supervision or appraisals in line with the policy of the service.

The training matrix did not show staff had received training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards which meant staff did not have a full understanding of the Mental Capacity Act 2005 and limited understanding of the Deprivation of Liberty Safeguards (DoLS).

People were given choices about their care and how they lived their lives but their consent to receive personal care was not always sought in line with legislation and guidance. It was not clear whether people acting on behalf of people had a Lasting Power of Attorney (LPA) in place to act lawfully on their behalf.

People enjoyed a nutritious diet but improvements were needed to make the dining experience enjoyable for all the people who lived at the home.

People had access to healthcare services and received on-going healthcare support.

Is the service caring?

Requires improvement 

The service was not always caring

Summary of findings

People who used the service felt staff were very kind and caring.

Relatives felt staff were very welcoming and had a good understanding of peoples support needs.

We saw staff interacted in a warm and caring manner with some people living in the home but this was not consistent within the staff team.

The environment was not always nurturing to people's needs. In three of the units the atmosphere was not relaxed with a lot of background noise.

People's dignity was not being maintained because staff did not have time to attend to people in a timely manner.

Is the service responsive?

Requires improvement

The service was not always responsive

People were not routinely involved with their care plan and review.

Care records were extensive but not always responsive to people's needs and were not person centred. Some of information in the care plans contradicted each other.

The lack of planned activities meant there were few opportunities for people to follow their interests.

Complaints had not been dealt with in accordance with the policy of the service. People had to wait up to four months for their complaint to be dealt with

The service did not use learning from accidents/incidents and the use of ABC charts.

Is the service well-led?

Requires improvement

The service was not always well led.

The registered manager told us they had a good understanding of their roles and responsibilities. However, this was not reflected in their practice.

Staff felt they were supported by the registered manager in their day to day roles.

The registered manager had not followed the policy in relation to supervising staff and carrying out appraisals.

Lydgate Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 3 and 7 September and was unannounced.

The inspection team consisted of four adult social care inspectors.

Before the inspection we reviewed information we had received from the provider such as notifications.

We spoke with nine residents, three visitors, and a visiting community nurse during the inspection process. We spoke with the registered manager, a senior care assistant and six care assistants.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework Inspection (SOFI) to observe interaction between staff and residents in one of the communal lounges. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed lunch in four of the dining areas and we observed care interventions throughout the inspection process. We reviewed eight care files, and daily records, four staff files and the maintenance and audit records for the home.

Requires improvement

Is the service safe?

Our findings

We asked people who lived at Lydgate Lodge whether they felt safe living there. They all told us they felt safe living at the home. One person told us "I feel safe here, the staff know what they are doing." Another person told us "If I wasn't happy with anything I would talk to the manager." We spoke with three visitors to the service. One visitor told us "Couldn't ask for a better place, (relative) very safe and content."

We spoke with staff who confirmed they had received training in safeguarding; they were able to give us a good description of the different types of abuse and what they would do if they had any concerns. However, in the training matrix we looked at we saw staff training in safeguarding was out of date. This meant people were at risk because the registered manager had not taken steps which ensured staff had the necessary training.

We spoke with the registered manager about safeguarding. They told us they were aware of what constituted abuse and how they would refer incidents to the local authority safeguarding unit. They told us "I would report anything that's a risk, mainly physical incidents. In the training I had I was told not to report incidents of people shouting if there has not been an impact."

Some people who used the service exhibited behaviours which could be seen as challenging. The registered manager told us they used records called Antecedent Behaviour Consequence (ABC) charts to monitor incidents of such behaviours. The use of ABC charts enables staff to identify trigger factors that can result in a specific behaviour and reduce the risk of the behaviour being repeated.

We looked at the ABC charts and saw ten recorded incidents since April 2015 where people had been involved in situations where they had shouted at other people, made threats of harm and had kicked out or hit out at other people and staff. The registered manager told us these incidents had not been referred to the local safeguarding authority team or to the Care Quality Commission because there had been no physical injuries. The provider should ensure that staff understand what constitutes a safeguarding incident and the importance of reporting these to the appropriate authorities. This meant that people could be at risk of harm without appropriate protections in place

The ABC charts indicated some people were victims on more than one occasion. We discussed our concerns with the registered manager. They told us they were aware of the issue but had not taken any action to prevent or reduce the risk of harm such as considering moving one of the residents to another part of the home.

We looked at the safeguarding records which detailed the referrals made to the local safeguarding authority team. It confirmed what the registered manager told us that they had only made referrals where an allegation of physical harm had been recorded. This meant the registered manager had not followed the guidelines in the safeguarding policy of the service and showed the reason for the low numbers of safeguarding notifications.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as this meant people who used the service were at risk because the service had not taken steps to prevent people being harmed.

During our use of the SOFI at lunchtime we observed little interaction between staff and people who used the service. This was because staff had intermittent presence in the lounge for the 35 minute period we observed. On another unit between 10:05 am and 10:25 no staff were present. This meant people who were vulnerable to falls had been left unsupervised. For example in one lounge, one person, who had limited vision, was hard of hearing and required support when mobilising was asking to go to the toilet. We saw they were becoming anxious as they waited. They got up from their chair and started to walk round the lounge area unaided. Other residents in the lounge were shouting to the person "Sit down and wait." The member of staff doing the medicine round tried to talk to the person and asked them to wait. However, because the staff member had their back to the person, they could not hear what was being said to them. We could see they were becoming more anxious and still trying to find their way out of the lounge.

After five minutes another member of staff came into the lounge and assisted the person into a chair without asking

Requires improvement

Is the service safe?

them what they wanted. Other residents in the lounge then told the staff member the person wanted to go the toilet. Ten minutes after the person initially requested support to go the toilet a staff member was able to support them.

We had received a whistleblowing alert with concerns that staffing levels were very poor in the service. As part of our inspection we looked at the staffing levels and the staff rota which showed there were ten staff on duty during the day and five members of staff during the night. The registered manager told us two new staff members had been recruited, one on the day rota and the other on the night rota. The registered manager told us they hoped the two new staff members would help address the shortfall in staffing numbers.

We asked people who used the service what they thought of the staffing levels at the home. One person told us "It's lovely here but they need more staff." Other people told us "The staff are lovely but there are not enough of them." Another person told us "There isn't enough staff because sometimes I have to wait. Last night staff didn't get me ready on time and they (staff) said 'I didn't have time, can't you see how busy I've been'"

We asked staff what they thought about the staffing levels at the home. One staff member told us "We know people need attention but cannot always get to them if we are busy with others." Another staff member told us "We can't be in two places at once and it is frustrating knowing people have to wait

We asked the registered manager how staffing levels were determined. They showed us the dependency tool used to determine the number of staff allocated to each of the four units. The registered manager told us the number of staff allocated would depend upon the level of risk and peoples support needs. We noted no matter what people's support needs or risks were two members of staff were allocated to each unit. For example; on one unit four people required two staff members to mobilise, five people required support of two staff in relation to incontinence and three people required support from two staff members for their hygiene and personal appearance. Two staff members had been allocated to that unit.

On another unit, two people had been assessed as requiring two staff members to support them as they mobilised, with their continence and with their hygiene and personal appearance. Two staff members had been allocated to that unit.

This meant the dependency tool was not being used to accurately determine the number of staff required on each unit. We discussed our findings with the registered manager. They felt the way they allocated staff using the tool was effective. On the second day of our inspection, the registered manager told us they had reflected on the use of the dependency tool and had started to allocate staff in a way they felt was more effective. For example, they told us they had allocated three members of staff to one unit as the level of support required by people who used the service was greater.

The home monitors and records the length of time it took the care staff to respond to call bells. We looked at the records for a four day period from Friday 4 September to Monday 7 September. We saw there were times when people had to wait more than ten minutes for staff to respond. One person told us "I have had to stop being embarrassed when I wet myself and get used to the fact staff are too busy to help me." A visitor to the home told us their relative "had resigned themselves to a long wait to use the toilet because staff are busy and take a long time to answer the bell."

During the inspection, we observed one person became distressed because they had to wait to use the toilet. The inspector had to go and look for staff to support the person because no staff were present on the unit. This evidenced the registered provider had not ensured sufficient numbers staff were employed to ensure they could meet people's assessed care and support needs.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 200 (Regulated Activities) Regulations 2014 as people's dignity was not being respected because there were not enough staff to respond to people's needs in a timely manner.

During our visit we looked at the systems in place for the receipt, storage and administration of medicines. We saw that the majority of medicines were supplied to the home in a Monitored Dosage System (MDS). Medicines which could not be included within the MDS were supplied in bottles or boxes.

Requires improvement

Is the service safe?

We checked a sample of MDS's to see if the number of medicines available tallied with the number of medicines recorded as received and administered. One of the medicines we checked did not tally as there was one less tablet in the box than the amount signed as administered. We discussed this with the manager and they told us they would investigate this discrepancy. We looked at the storage and records of administration of controlled drugs (CD's) in the home and found systems to be safe with appropriate records maintained.

We saw that medicines in use were stored within locked trolleys which, when not in use were kept in locked clinical rooms where the temperature of the room was appropriate for the safe storage of medicines. However, we saw that medicines waiting to be returned to pharmacy were in unlocked cupboards in the treatment room. We discussed this with the registered manager and they have told us they would take action to resolve the issue.

We observed three medicine rounds on two units. On one unit we observed the staff member supported people to take their medicines appropriately. However, during another medicine round we saw a staff member put a tablet from its package straight into their hand. We saw the staff member had dropped a tablet onto the floor, they picked it up and administered the tablet to a person living in the home. We discussed this incident with the registered manager. They told us they had addressed this incident with the member of staff concerned. The member of staff acknowledged they should have disposed of the tablet in line with the medicines policy of the service.

Some of the chairs on one unit were damaged and torn which meant they would not be able to be cleaned effectively. We also noted that when a person had been incontinent of urine, the chair they had been sitting in was not cleaned and another person sat in the chair. This meant there was a risk people who used the service were not being protected from the risk of infection because the service had not taken steps to clean the chair before the person sat in it.

These examples demonstrate a breach of Regulation 12 2(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had not taken steps that ensured the proper and safe management of medicines and preventing the spread of infections by not ensuring the chair was clean.

Once the person had been given their medication, the member of staff walked away without checking the tablet had been swallowed. Another staff member realised the person had not swallowed their tablet and gave them a cup of water to help them swallow it. They did not stay to check the person had in fact swallowed their tablet. The person had been chewing the tablet for 2 minutes before another staff member came back and encouraged them to swallow their tablet.

We did see some good practice when medicines had been administered. We saw staff sat down next to the person at eye level and explained to them what the medicine was for. We saw people asking for and being given painkillers. One person started to cough as they were taking their medicine. We saw the staff member sit down next to them and made sure they were comfortable before finishing the medicine round.

The training matrix we looked at showed staff had received training in administering medicines but this training was out of date. The manager told us all mandatory training was to be updated over the coming weeks. We saw staff had received a competency check in the safe administration of medicines in April 2015.

Requires improvement

Is the service effective?

Our findings

People who used the service told us they felt staff had the skills and knowledge to support them. One person told us "Staff seem to have the skills and knowledge."

The service had a recruitment and selection process in place. This ensured they recruited staff with the necessary skills and knowledge for their role. The service had just introduced a new induction process. This involved staff having a block of training prior to them starting work in the service. Staff we spoke with who had experienced this induction felt it was very useful and gave them the skills and confidence to carry out their role. The induction included training in safeguarding, moving and handling and first aid.

The registered manager told us all staff employed had the same training, which meant they were able to change roles. For example, two people who were employed in domestic type roles were often used as care assistants when the service was short staffed. We saw an example of this on the staff rota and on the day of our inspection. On one of the units, we saw staff who would normally work in the laundry supervising people for up to 45 minutes and providing practical assistance over the lunchtime period. They clearly had a good relationship with people and interacted with people in a warm and sensitive manner. On the staff rota on 14 August two people employed as domestics had worked a night duty as care assistants. The registered manager told us the two people had received the same training as the care assistants and were qualified to carry out the role.

We asked staff what they thought about the training in the home. They told us they had received training in a variety of subjects such as safeguarding, moving and handling and dementia awareness. They felt the training gave them the skills and knowledge required to support people.

We looked at the training matrix and saw staff training was out of date including safeguarding. The safeguarding training for 22 out of the 40 staff employed had expired. Additionally not all staff had received refresher training on moving and handling. We spoke with the manager about this. They told us they were in the process of updating people's training all mandatory subjects including safeguarding and moving and handling would be taking place in the upcoming weeks. We have asked them to send us documentation to evidence staff training.

Two members of staff we spoke with told us they felt the one day training in dementia awareness was not enough and they felt further training in dementia would be beneficial.

Supervision enables staff to receive support and feedback about their performance and practice. It helps staff develop their skills and knowledge. Supervision within the service was not consistent or in line with the policy of the service. Only one member of staff we spoke with told us they had regular supervision, every three months. This was confirmed in their staff file. However, other staff we spoke with could not recall having had supervision more than once in the past year. In other staff files we looked at there was no evidence staff had received supervision

None of the staff we spoke with could confirm they had received an annual appraisal. We spoke with the registered manager about this. They told us they recognised this omission and that they had been asked by their manager to sort this out." Appraisals are an effective way for staff to identify avenues of professional development with their manager.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant people who used the service were at risk of harm because the service did not offer staff support or the opportunity to learn and develop their skills and knowledge in line with the policy of the service.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We asked the registered manager to tell us how many people were subject to a DoLS authorisation. They told us only four people had such an authorisation in place despite people's liberty being restricted in two units due to the presence of the key pad. The registered manager told us none of the people had the code. The reason for this was because people had been assessed as being at risk of harm

Is the service effective?

if they left the floor unsupervised. We asked the registered manager whether a DoLS authorisation was in place for people who were asking to leave but were not able to. They told us they had not made an application for everyone, only for people who had been assessed as not having the capacity to make a decision about staying in the home but were making efforts to leave. The home had not assessed everyone in relation to their ability to make decisions about staying in the home. This meant people's rights were not being up held appropriately because the service had not taken the required action to ensure that the legislation was being correctly followed for people who lacked capacity on that unit and were asking to leave.

We asked staff about their knowledge of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). There was a variable understanding amongst staff. Some staff were able to give us examples of when people would be subject to a DoLS whilst other staff were not aware of when a DoLS application should be made. In the training matrix we looked at there was no evidence staff had received training in the MCA 2005 or DoLS. This meant people's human rights were at risk because staff did not have a clear understanding of when to apply for DoLS and when people required an assessment of their capacity to make a decision

These examples demonstrate a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant people who used the service were at risk of being unlawfully detained because the service did not have the lawful authority to keep people in the home.

We discussed this issue with the registered manager. They told us there were plans in place for all staff to receive an update in their MCA and DoLS training over the next few weeks. We have asked them to send us a copy of the updated training matrix.

However in one of the records we saw evidence where a DoLS application had been made it had been done appropriately. We saw capacity assessments had been carried out appropriately and in line with the Mental Capacity Act 2005. This meant that the service had taken steps which ensured people's rights were being protected in this instance.

In the care records we looked at we could not see people had consented to personal care, only for people to see their care plan. This meant that people who lived at the home had not been consulted about the care and treatment provided for them. We could not see evidence people had been supported to express their views and were actively involved in making decisions about their care, treatment and support.

In two of the care records, we saw a relative had signed on behalf of the person. They had a Lasting Power of Attorney (LPA) and therefore had a legal right to sign on behalf of the person. In another care record, we saw a next of kin had signed the persons care plan but we could not establish whether they were that persons LPA. A Lasting Power of Attorney is a legal tool that allows a person to appoint someone to make certain decisions on their behalf. The appointed person can make decisions relating to a person's health and welfare.

The provider should ensure that only people appointed as a LPA should be able to sign consent on behalf of other people as there was a risk that people's rights were not being protected if family who had not been nominated in this way signed on their behalf. We discussed this with the registered manager. They were not aware of this as an area of concern and did not have any plans in place to address it.

These examples demonstrate a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant the service had not asked people for their consent to carry out any care or treatment.

The service was prompt to call in other professionals when required. We spoke with one professional from the community nursing team and they told us they had good communication with the home and were satisfied with the level of care.

Parts of the home supported people with a diagnosis of dementia or other memory problems. On one unit, we saw pictorial menus in use so people could understand what the meal was each day. However on the day of the inspection, we saw a picture of a pint of milk and a plate of meat. This bore no resemblance to the meal that was to be served. We discussed this with the registered manager. They told us they would address this and ensure the

Requires improvement

Is the service effective?

pictures reflected the meal being served. Staff said people were asked the day before what choice of meal they would like. Staff told us sometimes people forget what they had chosen but alternatives were available.

The mealtimes at Lydgate Lodge was varied. In one unit we saw people were offered a choice of vegetables with their main meal. This did not happen on other units. Al the meals were pre-plated and set down in front of people. People were not offered a choice of portion size or whether they wanted gravy with their meal. The meal was just presented to people. On another unit, we saw people offered a choice of vegetables with their meal. The meal served on the day of the inspection looked nutritious

We saw from one person's care file they had lost 3kg in weight in the last six months. The care plan stated this person should be weighed weekly but this had not been done. We raised this concern with the registered manager; they told us they would investigate this incident and ensure the person was weighed. In other care plans we looked at we saw weights had been recorded and people had either maintained or gained weight. This showed the service ensured the majority of people's nutritional needs were monitored and managed

Requires improvement

Is the service caring?

Our findings

We asked people if they felt they were being respected by staff and they told us they felt staff were caring and considerate. One person we spoke with told us "They (care staff) are lovely and treat me with respect." Other people told us "Staff are very kind and caring. Can't fault them they are so good to me." One of the visitors we spoke with told us "The staff are all lovely."

Staff we spoke with told us they felt people were treated with dignity and respect. We saw staff knocked on people's bedroom door before they entered and they talked to people in a respectful way. We saw staff spoke with people in a calm and caring way, giving re-assurance to people who were distressed. We saw staff had fun with some of the residents and in one of the units there was a lot of laughter. On another unit, we saw staff spent time sitting with people and engaging them in conversation. Where people had difficulties communicating, we saw staff sat down next to them and held their hand. People were offered a choice of what films to watch on the television. Once the film had been chosen, people came to sit in the lounge and watched television together. The film was a very popular choice and people enjoyed it.

However, this was not the same on all the units. As a staff member was administering medicines we heard them say "(Person) was being very vocal today" and said "She's driving me mad". This was said in front of other people and did not display any sensitivity to the privacy and dignity to people who used the service. On another unit we saw a staff member supporting people from the dining area to the lounge. As they walked with the person, they were not engaging with them but watching the television. Another person sat at the dining table whilst it was being cleaned by a staff member. There was no conversation between the member of staff and the person sat at the table.

One of the people we spoke with told us they had resigned themselves to waiting long periods of time for staff to help them. In one case, one person had become incontinent because there were not enough staff to meet their needs in a timely manner. They told us "I have to tell myself not to worry if I wet myself because staff can't see to me in time."

We discussed our findings with the registered manager. We told them although we had seen a lot of respectful, caring interaction between staff and people who used the service this was not consistent. They told us they would address with the staff team. They did not give us a date when they would do this.

The care records showed people were not being routinely involved in the development and review of their care record. We asked two people who used the service if they had been asked about their care record. They told us they did not understand what we meant by care record and did not know who their keyworker was. Another person told us they were aware of their care plan and could tell us who their keyworker was.

Although people we spoke with did not attend the resident meetings, we saw resident meetings did take place. We saw the minutes from three of the meetings which took place in the different units. The agenda covered activities and in the meeting people reported feeling they were not being informed of what activities were taking place. We discussed this with the manager but they did not tell us what they would do to inform people what activities were taking place.

The registered manager told us there were no restrictions on how often people had visits from friends and relatives. We saw relatives and friends visiting on the day of our inspection. We saw them making tea for themselves and their relatives. Visitors we spoke with confirmed they felt welcomed by staff when they visited.

Requires improvement

Is the service responsive?

Our findings

We asked the people who lived at the home what they thought about the activities which took place. One person we spoke with told us "I'm fed up, I'm going dolally, nothing takes place and there's no fun." Other people told us 'I am fed up, there's nothing to do.' One person told us they wanted more outings to 'Stop the monotony and have something to look forward to.'

We saw previous activity programmes which included; chair exercises and external entertainers. Up until March 2015, the service had a weekly activity plan in place. We asked the registered manager why weekly activity planning has stopped. They told us they didn't do a weekly activity plan because "People told us weren't really interested in planning activities. They don't like to mingle with other people in the home." This statement from the registered manager was contradicted by the fact there was no record confirming people had stated they did not want activities planned on a weekly basis. In fact in the resident feedback questionnaire for June 2015, one person stated 'We don't seem to know when activities are happening in the home.'

We looked at feedback questionnaires people who used the service had completed and the minutes of two resident meetings. We saw people felt happy with the amount of activities which took place but felt there could be a greater variety. People had asked for more day trips out. We asked the registered manager whether these had been arranged. They told us they had tried to arrange a trip out but it was cancelled because people had changed their mind. They had plans in place to arrange another trip but these had not been shared with people who used the service.

This showed that people who lived at the home had been consulted about the care and treatment provided for them.

People were supported to express their views and were actively involved in making decisions about their care, treatment and support

The care records were comprehensive and covered areas of need such as; personal care, mobility and communication. Although the care records were comprehensive, they were very generic and were not person centred. This is important as most people who lived at the home had memory impairments and were not always able to communicate their preferences.

We saw examples of a lack of person centred approach in people's daily records. For example we entries which read "(Name) was very agitated upon my arrival to the flor" and "(Name) was walking around the unit on my arrival. This meant people's dignity was not being respected

One of the records we looked at we saw contained contradictory information, which would make it difficult for staff new to the service to establish the care needs of the individual. In another care record we saw the person had been assessed as having failing eyesight. This was not referred to when a risk assessment was being carried out for their mobility.

We noted in one person's care record that on two separate occasions, staff had recorded the person saying they 'wished they were dead'. On another occasion staff had recorded the person was 'upsetting other residents by saying she wished she was dead all the time, residents were telling her to go away'. We saw from the person's care plan that staff were to use 'distraction techniques' when the person expressed a wish to die. However it did not detail what these were and did not consider what might have happened to make the person feel this way at that time. We did not see any evidence of how staff had supported the person as a result of any of these incidents.

Some people who used the service lived with dementia. Enabling people with dementia to take part in meaningful and enjoyable activities is a key part of 'living well with dementia'. The service did not employ an activity coordinator as staff were expected to carry out activities as part of their role. The registered manager told us there were no morning activities because staff were too busy carrying out personal care. All activities took place in the afternoon. On the day of the inspection we observed people were given pictures and books for them to colour in as an activity. We talked to the registered manager about the type of activities they organised. They told us people enjoyed colouring and they had bought colouring books for people to use and they classed this as an activity. However, in the residents' meetings minutes we looked at we could not see any evidence people had requested colouring books as an activity. This contradicted what the manager had told us. On one unit nobody wanted to colour in and no alternative activity was planned. This showed the service was not meeting the social needs of people who used the service.

Requires improvement

Is the service responsive?

These examples demonstrate a breach of Regulation 9(1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This means the service did not provide care and treatment that was not person centred and did not reflect people's personal preferences.

We looked at the complaints file. We saw not all complaints had not been logged appropriately and other complaints did not have the outcomes recorded in detail. For example one outcome just stated 'Taken to staff meeting.' There was no record indicating what lessons had been learnt from the complaint.

We looked at a letter dated March 2015 and written record of a meeting held in April 2015 by the deputy manager. The two documents were from a relative who had raised concerns in relation to the levels of staffing and other incidents such as money and clothes missing from their relatives room. We asked the registered manager whether these records had been logged as a complaint. The registered manager told us they had only just become aware of the issues so had not yet logged the concerns as a complaint. When we brought this to the attention of the registered manager on the first day of inspection they told us they had plans in place to contact the relative to address their concerns. However, on the second day of inspection, they had not contacted the relative as they said they would and the concerns had not been logged a complaint.

Other complaints we looked at had been investigated with outcomes and plans of action. Although some complaints had been dealt with appropriately, we felt the registered manager had not handled complaints in line with the complaints policy of the service.

These examples demonstrate a breach of Regulation 16(1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The service did not investigate concerns and complaints raised by relatives of people who used the service. This meant that no appropriate action had taken place in response to concerns and complaints.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in place. 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.

Two of the care records we looked at contained contradictory information which meant people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not being maintained.

We asked staff whether they attended staff meetings. They confirmed staff meetings had been held and we saw the minutes of two staff meetings one held in January 2015 and one in April 2015. There was an agenda for each meeting and covered issues such as safeguarding, fire safety training and the role of keyworker. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment for people living at the home.

Residents meetings were held by the registered manager but these were not on a consistent basis and did not include all the people who used the service. This meant the service did not provide an arena whereby people who used the service had been able to consistently express their views and were not involved in making decisions about their care and treatment.

We spoke with staff who told us they felt supported by the registered manager. Even though staff did not received supervision they told us they felt able to approach the registered manager at any time. Staff did not have a clear idea about the vision or the culture of the home. However, they all felt the staff team worked well together.

The registered manager told us they spent time during the day visiting the different units. We saw the registered visited two units for five minutes during the two days of inspection. At the end of the first day of inspection, the registered manager was in the office preparing for their garden party. This involved sticking raffle tickets to prizes. This was in spite of the fact the units were short staffed and people were having to wait to have their support needs met. This meant the registered manager did not regularly work with staff 'on the floor' providing support to people who lived there.

The registered manager told us they felt the staff team had a good attitude on the whole and had observed the caring nature of the staff team. In the only supervision record available we saw the registered manager had addressed poor attitude of the staff member. However, within their supervision record it was not made clear whether the staff attitude had changed as a result. Although we discussed this issue with the manager, they did not tell us what they had done as a result.

We asked the registered manager about their role and their responsibilities. They told us they had a good understanding of what was expected of them. They felt supported by their own line manager and other managers within the service. They acknowledged staffing levels were an issue. They told us staffing levels would improve when the two new members of staff were in post.

The registered manager was not aware of the length of time people had to wait for their calls for support to be answered. We could not be sure the manager was auditing the call bell response time.

We looked at the quality assurance system files. We saw all health and safety checks had been carried out by the maintenance staff and were up to date. This meant people were being protected from the risk of harm because the service had taken steps which ensured systems and equipment were safe to use.

We looked at the fire safety log book. We saw the service should be carrying out monthly fire drills but these had not been carried out in line with their own policy. The registered manager has assured us they will rectify this. We saw all people who used the service had in a place a Personal Emergency Evacuation Plan (PEEP) in place. The PEEPs meant care staff and other professionals involved in an evacuation of the premises, would have the knowledge of how to support each person in the event of an incident such as a fire.

The registered manager told us all accident and incident reports are routinely sent to their head office for analysis. The head office would then contact the manager if they discovered any untoward incidents or accidents had not been dealt with. Each month, the registered manager sent

Requires improvement

Is the service well-led?

all safeguarding referrals to the area manager who carried out an audit of all referrals made that month. The registered manager was not carrying out their own audit of incidents and safeguarding referrals. This meant they would not be able to identify trends or patterns and learn from any incident. We did not see any records of audits carried out by the head office. The registered manager told us they would only have sight of the audits if there was a problem.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The manager was not referring incidents to the local safeguarding authority team.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's dignity was not always respected. People had to wait for long periods of time for staff to respond to their call bell. Some people had resigned themselves to waiting long periods of time to use the toilet. One person had resigned themselves to having to be incontinent because they could not always wait for staff to support them. 10(1)

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 People were not able to leave the unit because a keypad system was in place. The registered manager had not given people the code to the key pad system. Although the registered manager had applied for a Deprivation of Liberty Safeguards authorisation, this was only for four people. 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Staff were not being offered supervision and appraisals in line with the policy of the service. Training for staff was out of date. 18(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service had not taken steps that ensured the proper and safe management of medicines and preventing the spread of infections by not ensuring the chair was clean. 12(1)(2)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent This meant the service had not asked people for their consent to carry out any care or treatment. 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans were not person centred and did not reflect people's preferences. 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered manager was failing to notify incidents within the service to the local safeguarding authority.
	The service did not always investigate concerns and complaints raised by relatives of people who used the service. This meant that no appropriate action had taken place in response to concerns and complaints. 16(1)

This section is primarily information for the provider

Enforcement actions

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