Care Quality Commission

Care Uk Community Partnerships Ltd

Harry Sotnick House

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

The inspection took place on 10, 11 and 17 February 2015 and was unannounced.

The home provides care and accommodation, including nursing care for up to 92 older people including those living with dementia. At the time of the inspection 81people lived at the home. The home is purpose built and is divided into six units each with a communal lounge, dining facilities and bathrooms. There were also rooms and facilities where people could undertake activities and meet with visitors in private.

At the time of the inspection the home did not have a registered manager. An acting manager had been in place until four days before the inspection. The home has been without a registered manager for approximately a year and has had interim acting managers during this time. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

At our last inspection on 6 October 2014 we found the service was in breach of a regulation as medicines procedures were not safe. We took enforcement action by issuing a warning notice as this was a continued failure to meet this regulation. At this inspection we found medicines procedures were still not meeting the regulations and people did not always get their prescribed medicines.

At the time of the inspection management support was being provided by several of the provider's regional managers. There was an acknowledgement from the regional managers that the home has not been effectively managed. One of the managers said, "It all fell apart in the last few months." We found significant failings in the delivery of care, and in the management and supervision of staff. This had impacted on the welfare of people.

People and their relatives gave us mixed views about whether people were safely cared for. We found a number of areas where people's safety was compromised. This included incidents not being reported to the local authority safeguarding team in a timely way. The right equipment and care was not always provided so people received safe care and in one case a person suffered an injury due to the provider failing to follow the advice of a health care professional. Lessons were not learned from such incidents so they did not happen again.

Sufficient staff were not deployed to safely meet people's needs. On one unit staff were not provided as set out in the staff roster, which the home's management were not aware of. People at risk of injury or with positive behaviour support needs were not monitored to keep them and others safe.

Medicines procedures were not always safe Two people had not received their pain relief medicines.

Staff had access to a range of training courses but we found a number of staff had completed few of the courses on the home's own training plan and system. Training to induct newly appointed staff was unclear and registered nurses commented they were given limited support and guidance before working with people.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Procedures for obtaining people's consent to their care and treatment did not always follow the appropriate guidance. There was a lack of evidence on care records that people had consented to their care. Where people lacked capacity to consent to their care and treatment we saw examples of people's capacity to consent being assessed and a best interests care plan as required by the (MCA) 2005. We also found examples where these procedures had not been followed. The provider had failed to apply to renew one person's Deprivation of Liberty Safeguards (DoLS) authorisation which meant the person's liberty was being restricted without proper legal authorisation.

We observed people were supported to eat and drink and there were positive comments from people and their relatives about the quality of the food. We noted for two people who had lost weight there was a lack of guidance in care plans for supporting them to eat.

People's health care needs were monitored and people had access to a nurse practitioner and GP from a local doctor's surgery. Advice and guidance from health and social care professionals was not always followed.

We saw examples of staff being compassionate and caring with people. Relatives gave us mixed views about the caring nature of staff. Staff did not always know about the people they were providing care to and we observed one person had laid themselves on the floor which staff knew about but did not monitor the person's safety adequately.

People and their relatives gave us examples of how staff responded to people's needs. This was also something we observed. We also found, however, a number of instances where the provider and staff did not respond to meet people's changing needs. Care plans were not reviewed and updated in line with the provider's procedures and we observed staff carrying out care procedures which were not included in care plans. People's care plans and assessments contained contradictory and inconsistent information. Several staff told us they did not read or have access to all of the care plans for people. Whist there were activities for people these were not provided to all people, especially those living with dementia.

Concerns and complaints were not always acknowledged, investigated or responded to in a timely manner. The provider failed to act and look into some complaints and concerns raised with them with the result that people were placed at risk of harm.

Summary of findings

The home was not well led. There has been a lack of effective management at the home. Senior staff were not always aware of what was going on in the different units and staff did not always know people's needs. Audits and checks failed to address or identify concerns and when they had, action was not always taken to prevent them reoccurring.

Notifications had not always been made to the CQC as required by the regulations. The management of records was inadequate with a lack of security to keep care records confidential. There were incorrect dates on documents and some staff did not have access to the computerised records.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Whilst staff knew how to report any suspected abuse, significant incidents and injuries to people were not always referred to the local authority safeguarding team. The provider had not acted in line with local safeguarding guidance in responding to allegations of abuse

People who displayed behaviours which may challenge were not always appropriately supervised and monitored to ensure their safety. Staffing levels were not sufficient, specifically in two units where people needed additional support and supervision. Staffing was not always provided as planned on the daily staff roster to meet people's needs.

The provider had not managed risks to people to prevent them being injured and to prevent possible reoccurrences of injuries.

The provider had not fully complied with a Warning Notice in relation to managing medicines safely. People requiring medicines for pain relief did not receive this consistently or safely.

Is the service effective?

Inadequate

The service was not effective.

Training, supervision and appraisal of staff was inconsistent. Two registered nurses stated they did not receive adequate training and support when they started work. There was a lack of clear processes for assessing that newly appointed staff were competent to provide care to people.

There was a lack of information in care plans to show people were consulted and had consented to their care. Where people did not have capacity to consent to their care the provider had not always followed the procedures and guidance of the Mental Capacity Act 2005. This included an omission in making an application to renew a DoLS authorisation, which meant the provider was restricting a person's liberty without legal authority.

People's nutritional needs were inconsistently assessed. Whilst people were supported to eat and drink one person had lost significant weight and there was no care plan of how this was to be addressed.

People's health care needs were assessed by a visiting GP, a nurse practitioner and a continuing health care nurse. The advice and guidance as given by health care professionals was not always followed which had a significant impact on the safety of people.

Summary of findings

Is the service caring?

Requires improvement 

Staff did not always know the needs of people they were caring for. Whilst there were examples of staff treating people with kindness and dignity we also found staff did not always treat people with compassion.

There were examples of people's dignity and privacy being promoted but we also found examples where this did not take place.

People's views were listened to and people were given information about the arrangements for their care.

Is the service responsive?

Inadequate 

The service was not responsive.

People did not always receive personalised care that was responsive to their needs. Advice and guidance from health care professionals regarding the provision of equipment for people was not always acted on. Care plans and the delivery of care did not always reflect the assessed needs of people.

There was an activities coordinator and activities were provided. These did not always include all of the people in the home, particularly in one of the units where we observed people and staff over two days.

The provider did not handle and respond to all complaints in a timely manner. Satisfactory action was not taken when concerns were raised with the provider, which placed people at risk of harm.

Is the service well-led?

Inadequate 

The service was not well led.

The service did not have a registered manager and has not had a consistent manager for the last 12 months.

We found a culture where staff and the home's management did not communicate effectively, which in some cases led to people's needs not being met. The home's management were not always aware of which staff were on duty in the units. Staff were moved around from unit to unit and as a consequence did know always know people's needs.

Notifications of incidents in the home were not always made to the local authority safeguarding team or to the Commission.

The service did not have robust records and not all staff, including registered nurses, were able to access the care records held on the specially designed care planning computer system.

Investigations into incidents did not always take place and when they did they did not always result in improvements to the care people received.

Harry Sotnick House

Detailed findings

Background to this inspection

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

The inspection took place on 10, 11 and 17 February and was unannounced.

The inspection team consisted of two inspectors, a pharmacist inspector, a specialist nursing advisor and an Expert by Experience, who had experience of older people's care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

Not all the people who used the service were able to verbally share with us their experiences of life at Harry Sotnick House because of their complex needs. We therefore spent time observing the care and support they received in shared areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with 14 people and eight relatives. We also spoke with 19 staff. These included care staff, registered nurses and domestic staff. We also spoke to the clinical lead for the home who was a registered nurse and was undertaking a number of management roles. We spoke with members of the regional management team for the provider including the Regional Director, a Quality Improvement Officer and a Regional Clinical Development Manager.

We looked at the care plans and associated records for 13 people. We reviewed other records, including the provider's internal checks and audits, training records, records of activities, staff rotas, accidents, incidents and complaints. Records for five staff were reviewed, which included checks on newly appointed staff, supervision records and the training of newly appointed staff.

We spoke to a registered nurse from the local health trust who visited the home on a regular basis to provide advice and support to care and nursing staff. We also spoke to an advanced nurse practitioner from a local GP practice who visited the home twice a week to review people's care needs. We spoke to social services commissioners and members of the social services safeguarding team regarding recent concerns raised with them. These people gave us their permission to include their comments in this report.

Inadequate

Is the service safe?

Our findings

At our last inspection on 6 October 2014 we found the service was in breach of a regulation in relation to unsafe medicines procedures. We issued a warning notice in relation to this as we found continued failures to meet this regulation. At this inspection we found medicines procedures were still not meeting the regulations to ensure safe practices in relation to this.

Appropriate arrangements were in place in relation to ordering, and disposal of medicines. Medicines were prescribed by people's doctor and were ordered in a timely fashion for continuity of treatment. Medicine no longer required when discontinued were disposed of safely by returning them the pharmacist. Records of medicines ordered, received, and disposed of were maintained. Medicines were stored safely in dedicated locked rooms with lockable cupboards, medicine trolleys and a fridge.

We observed medicines being administered by staff. There were systems, protocols and policies for staff to follow with regards to safe medicine management. This included checks and audits of medicine use, medicine administration records, temperature checks, daily medication patch check, and medicine receipt records. However, these systems were not always followed so people did not receive their medicines safely and consistently.

There were documents for medicines where the dosage instructions varied such as those given on an 'as required' basis. These included guidance for staff when this medicine was needed in response to symptoms, such as for neurological conditions and behavioural needs. However, for other symptom relief, such as pain management, guidance for staff was not always recorded. Staff therefore, did not have sufficiently clear guidance about when people needed this medicine. This meant there was a risk people may not receive their medicine when they needed it in a consistent way and could suffer discomfort as clear guidance for staff to follow was not recorded.

On two occasions people did not get their pain relief medicines at the prescribed times. These were slow release pain control patches administered two days late for one person and five days late for another. The provider had failed to administer medicines to people as prescribed by a medical practitioner, which meant people were not always treated for the relief of their symptoms. The result of this was that people were at risk of experiencing pain due to the failure to administer medicines.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. We found that the registered person had not protected people against the risks associated with the unsafe use and management of medicines. This meant the service remained in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives gave mixed views about feeling safe in the home. The majority of people and their relatives considered the home a safe place for people to live. One person said how they felt safe as staff always responded promptly when they used the call point to ask for assistance. However, one person said they were sometimes handled roughly by a member of staff when they received personal care.

Staff had a good awareness of what to do if they considered people were not being treated well or were being neglected or abused in any way. Training was provided for staff in safeguarding procedures but the provider's records showed only 67 of 134 staff had completed this. Referrals were made by the provider to the local authority regarding incidents classed within the definition of safeguarding. However, we found this had not taken place for a significant incident. Following this inspection the Commission received a notification from the provider which said an allegation by a member of staff of possible abuse had not been looked into or referred to the safeguarding team at the time of the allegation. This demonstrated that the provider had not responded appropriately to allegations of abuse in order to protect people from harm. We found that the registered person had not protected people against the risk of abuse by taking steps to identify the possibility of abuse and responding to any allegation of abuse. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Care records included assessments of possible risks to people and actions staff should take to minimise these. There were several examples where the provider had failed to manage risks which resulted in injury or the potential to cause injury to people. This included a failure to follow the advice of health care professionals regarding the use of specialist equipment for two people, which helped prevent people sustaining injuries from their nails cutting into their hands. For one of these people the provider failed to follow this advice from eight months previously and in the meantime the person was injured as a direct result of the lack of action. For the second person the advice of a health care professional for the use of this equipment was also not followed and had not been recorded in any care records. A registered nurse who worked on the unit this person resided in did not know about this advice and confirmed the equipment to protect the person was not in place. There was no care plan for the provision of this equipment or of how to manage the risk to injury to the person. For another person their pre admission assessment stated a pressure mat was needed to alert staff if the person got out of bed so action could be taken to keep them safe. The pressure mat had not been provided so the person was at risk of injury if they got up. Another person's assessment said they were at risk of developing pressure sores and that an air flow mattress was needed to prevent pressure sores. A memory flex mattress was provided instead of an air flow mattress with no recorded reason why. Known risks to people's safety and welfare had not been appropriately planned for to mitigate the risk of injury. Care had not always been arranged to in accordance with people's assessed needs. The advice of health care professionals had not been recorded or followed. The result of this was that people had been harmed, or were at high risk of harm in future.

We observed examples of ineffective risk management which resulted in an unsafe environment for people. One person's care plan said a person's hoist sling needed to be removed to prevent injury after the person was moved, but we found staff did not follow this. People had freedom to move around the units in the home but relatives told us people walked into each other's rooms which we observed during the inspection. During the inspection one person entered another person's room and caused an injury to the person. Staff alerted the home's management team to this and took action to report the incident to the local authority safeguarding team and to reassess the person's needs in order to prevent any similar reoccurrence. We also observed staff did not take action where a person's behaviour needs resulted in them laying themselves on the floor. Staff did not take action to support the person or to monitor they were safe as the person could have sustained an injury as other people who walked around the unit could have tripped over the person on the floor.

The above evidence demonstrates that risks to people's health and well-being were not appropriately managed. The planning and delivery of care did not always reflect people's assessed needs and did not ensure the welfare and safety of people. We found that the registered person had not protected people against the risks of receiving care or treatment that was inappropriate or unsafe. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient numbers of suitable staff were not deployed to meet people's needs and to keep people safe. People and relatives gave us mixed views about whether they considered there were enough staff on duty. The majority of relatives said there were enough staff to meet people's needs but others commented how staff did not have enough time to provide the appropriate care to everyone. Staff gave us mixed views about whether there were enough staff to safely meet people's needs. Four staff, including two registered nurses, said they did not normally work in the units we found them working in. Three of these staff said they did not know people's needs as they did not normally work on the unit they were deployed to. This meant the continuity of care was affected as staff did not always know people's care needs as staff were moved from unit to unit. People were at risk of unsafe or inappropriate care because some staff were not knowledgeable about their needs and risks.

People who presented with behaviours which may challenge others were observed to spend periods of time in communal areas with each other in Rother unit when staff were not present. This included seven people left alone for periods of ten minutes at a time. We observed people being aggressive to each other, shouting and swearing. In one case a person shook another person's walking frame and shouted loudly directly next to the person with the frame. Another person covered their ears because of the noise. Staff were needed to monitor and engage with

Inadequate

Is the service safe?

people who had behaviours which may challenge to ensure their safety. Instead of being available to offer this support, staff were elsewhere in the unit providing support to others. We observed staff were 30 minutes late serving lunch on one unit as they were providing care to people. Consequently, people waiting for their lunch were not attended to by staff as staff were providing support to people elsewhere in the home. On another unit, however, we saw the lunch was not delayed.

Staffing was organised on a roster by the home's management team. A daily allocation list of which staff were working in each unit was then devised. This said five care staff and one registered nurse were deployed to work in Rother unit but we found only four care staff were working there. The home's clinical lead registered nurse who devised the staff allocation was unaware of this. Staff had decided to move a care staff member to another unit without checking or discussing this with their line managers. The clinical lead registered nurse told us this practice had been "common place" and steps were big taken to prevent it happening.

The above evidence demonstrated that there were not appropriate systems to ensure there were sufficient numbers of suitably knowledgeable staff to meet people's needs and keep them safe. People's health, safety and welfare were at risk because the service did have enough staff in the right places to meet their needs in a timely way. We found that the registered person had not protected people against the risk of safeguarding people's health, safety and welfare by the provision of adequate numbers of suitably qualified, skilled and experienced staff. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Pre-employment checks were carried out on newly appointed staff including a Disclosure and Barring Service (DBS) check that staff were suitable to provide care to people. These checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. Records of staff recruitment showed the provider obtained written references on newly appointed staff including references from the most recent previous employer. These records also showed newly appointed staff were interviewed before being appointed so the provider was able to check the suitability of these staff to provide care to people. Staff confirmed their recruitment involved reference checks and a job interview.

Inadequate

Is the service effective?

Our findings

People and their relatives gave us differing views about the skills and knowledge of staff in providing effective care. One relative described the staff as "brilliant" and several relatives said staff were well trained to do their job. Other relatives did not feel all staff had the right skills to provide care. One relative commented that a staff member made inappropriate remarks when providing care and that some, but not all, staff found excuses to not carry out care tasks. This included a comment from a relative who felt staff did not get a person out of bed as it was easier to provide care for the person if they were in bed. Relatives said health care was arranged when needed such as dental treatment and GP appointments.

Induction training for newly appointed staff was not clear. One registered nurse said their induction consisted of 'shadowing' more experienced staff and they considered this was sufficient to prepare them for their work. However, they also said the formal induction they were supposed to have did not take place. We also observed a newly appointed registered nurse 'shadowing' a more experienced nurse as part of their induction. Two other registered nurses told us their induction was very brief, one of whom described it as "minimal" and that she was "thrown in at the deep end." The home's management told us staff were supplied with an induction handbook but for three recently appointed staff there was a lack of records to show how these staff were trained and assessed as being competent to provide care. These staff had, however, been assessed regarding their competency to administer medicines and had completed training in other courses.

Staff had access to a range of training courses including National Vocational Qualifications (NVQ) in care or the Diploma in Health and Social Care. NVQ's are work based awards that are achieved through assessment and training. To achieve an NVQ candidates must have proved that they have the ability and competence to carry out their job to the required standard. Staff gave us mixed views on the standard of training they received. For example, a senior care staff member told us how staff had access to NVQ training and that they encouraged staff to complete training courses. Another staff member, however, felt there was too much emphasis in the training by the use of interactive computer courses rather than face to face training with a tutor.

A spreadsheet of staff training was also maintained. Of the 135 staff listed on the spreadsheet more than 50 staff were recorded as not completing the majority of the 16 courses listed. These included training in safeguarding procedures. The spreadsheet did not record any staff as being trained in manual handling. Some staff had completed 15 of the 16 courses but others had only completed one of these training courses and these included registered nurses. This meant there was the potential staff did not have the skills to provide effective and safe care to people.

Staff, including registered nurses, told us they received supervision. Records of staff supervision, however, showed this was inconsistent. One staff member who had worked at the home for just under two years had a record of two supervision sessions and no appraisals of their work. For two registered nurses who started work approximately three months before our inspection one had a record of one supervision session and the other two. The lack of regular training meant the provider was not effectively monitoring the performance of staff regarding the provision of effective and safe care. Also, the lack of supervision meant staff may not have opportunities to discuss their work and the care of people.

We found that the registered person had not protected people against the risk of receiving care from staff who were supported in their responsibilities to deliver care and treatment to an appropriate standard by adequate training, appraisal and supervision. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was inconsistent in following the guidance and principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The care planning system used by the provider did not include a section to show people had consented to their care or treatment. We observed a member of staff carrying out a care procedure when they put a person to bed when the person was agitated. This was not recorded in a care plan even though the staff member said this was the procedure they followed. The care plan did not show the person had agreed to this. We observed a staff member ask this person if they were in agreement with the procedure, but this was only after we asked the staff member about this. We also found another person who had their medicines

administered by concealing them in food had a best interest decision about this, but there was no assessment of the person's capacity to consent to their medicines. The provider had assessed the capacity of other people and where people's liberty was restricted or decisions made in their best interests. However, we noted one person's care plan stated they were subject to a DoLS authorisation to keep them safe but was, in fact, not subject to the order as the provider had failed to apply to the local authority to renew the DoLS at the date it needed to be renewed. The provider was depriving the person of their liberty without the correct authorisation. We found that the registered person had not protected people where their liberty needed to restricted for their safety as set out in the MCA and DoLS legislation and guidance. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us the food was of a good standard and choices were available. We saw people were able to make choices and the day's menu was displayed. People were supported to eat and were provided with pureed food and aids to help them eat. We observed staff supported people appropriately at meal times. Staff were also observed to check with people if they wanted any additional food and drinks such as snacks which staff promptly provided. Drinks were available for people in their rooms and in the communal areas. Records were maintained where people needed to have their food and fluid intake monitored. For one person we noted these were made on a daily basis but we noted for two days in the week preceding the inspection that a daily total intake was not recorded which was needed to ensure the person's food and fluid intake was effectively monitored. There were two examples where we found people had lost weight and there was a lack of recorded care plans about how the weight loss was to be managed, such as nutrition supplements or high calorie food. This included one person who had lost 20kg over eight months. For one of these people the provider had made a referral to the dietician services but there was no record of this being followed up. We also found the assessments of nutritional needs were contradictory for this person. One assessment said the person did not need support with eating and drinking but another assessment identified the person was at high risk of malnutrition. We found that the registered person had not protected people against the risk of malnutrition and adequate fluid intake due to a lack of consistency in assessing people's needs and in planning and monitoring their delivery of care. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health care needs were assessed via the home's links with a local GP practice. An advanced nurse practitioner from the GP practice visited the home three days a week and a GP visited once a week to check on people's health care needs. The nurse practitioner told us people's health care needs were referred when this was appropriate. We saw records of the staff making referrals to the GP services, dietician and a speech and language therapist. Care records also showed people's health care needs were monitored such as blood pressure. People's health care needs were also monitored by the input of a continuing health care registered nurse who told us staff were inconsistent in following up the advice they gave. The continuing health care registered nurse gave examples where people's health care needs were addressed but also where specific advice given by them had not been implemented.

Requires improvement

Is the service caring?

Our findings

People and their relatives gave us mixed views about whether people were treated in a caring way. The majority of comments were that people were treated with kindness, respect and with dignity. One person said, “All the staff are lovely.” Another person said, “The carers are lovely, they take me outside, twice a day sometimes three times.” However, one person told us they were not always treated gently and said they were handled roughly. A relative said they observed a staff member talking to a person in a way they did not think was appropriate.

People and their relatives gave us examples where staff listened to what people said and acted on this. For example, a relative described how staff took account of her mother’s bed time routines of what she liked to wear and the time she went to bed. However, other relatives told us there were delays in getting people up in the morning as staff were too busy. Relatives told us they were made to feel welcome by staff when they visited and that they were able to spend time at the home when they wished.

Staff showed concern for people’s welfare and a caring attitude in most situations and we observed people were confident in asking staff for support. For example, one staff member said they loved their job and other staff demonstrated they were motivated to assist people in the best way they could. Staff were observed to treat people with kindness and compassion. Staff were seen to check people who were in their rooms, asked them if they were alright and if they needed anything. Staff knew people’s names, said hello to people and gave words of support. When people were supported with their meal we observed staff to be patient, calm, kind and they interacted well with people, such as having good eye contact. Staff had a good rapport with people who they knew well and adapted how they communicated with different people so it was easier for people to understand. However, we also noted the movement of staff between the different units meant a number of staff did not always know the needs of the people they were providing care to. Two relatives commented they would have preferred a staff team which did not change so often so staff could get to know people better and so people could become familiar with the staff. We observed staff assisted people when they appeared in distress or discomfort although we also noted staff failed to monitor someone whose behaviour posed a risk to themselves and to other people. For example, staff left a person alone who had chosen to lay themselves on the floor and failed to monitor they were safe.

Information was displayed on a notice board for people in the lounge areas which included the day of the week and date as well as other relevant information. One of these notice boards had the incorrect day and date which could cause confusion, particularly to people living with dementia .

People had their own rooms so personal care was provided in privacy. Copis of people’s care plans were provided to people in their rooms so people had information about how they were supported. There were occasions when we observed people’s dignity and privacy were not promoted and this included several instances of people living with dementia going into other people’s rooms without permission or staff awareness. One person was observed in bed fully clothed and staff did not know why this was. Another person was observed with unbuttoned trousers as they did not fit properly. Action was taken by staff only after the inspector informed them the person’s trousers did not fit.

Inadequate

Is the service responsive?

Our findings

We received mixed views from people and their relatives about the responsiveness of the service. For example, some relatives and people said staff were attentive and responded quickly when they used the call point in their rooms to ask for assistance. However, we observed some call points were out of reach of people and a social services professional raised this with us as a concern during the inspection. Staff were observed to help people with their requests for assistance but we also noted staff did not always respond to people's needs. People and their relatives said they felt able to raise concerns but several of these said they had not received a satisfactory or timely response to their complaint. For example, one relative who said their complaint was not responded to told us, "Management have not communicated properly and effectively with us." The relative said they had never met the acting manager despite making a complaint even though they regularly visited the home.

People did not receive care that was responsive to their needs. People's needs were assessed before they were admitted to the home. Care plans included details about how people were to be supported with their care. However, these were inconsistent. Information about assessed needs had not always been acted on when the person moved in, such as for the provision of a pressure mat and air flow mattress for people which were identified as part of the initial assessment. The provider had also failed to follow the advice of health care professionals to obtain equipment so people received appropriate care, such as equipment to prevent people's nails growing into the palms of their hands. People's care plans also failed to include full reference to care and dietary needs. In one case we found staff carrying out a care procedure that was neither recorded nor agreed with the person. We also found staff did not always follow the procedures recorded in care plans. Staff responded to people's needs and to their requests for assistance but we also found instances when this did not happen. For example, we observed one person had dirty nails which had not been cleaned and staff were not always attentive in supporting people in communal areas. This included people in Rother unit who were left unsupervised for periods of time when their behaviour indicated people needed to be monitored.

The care plan system being used included dates for care reviews so people's care plans could be updated to meet changing needs. We found these reviews were frequently not completed. A number of care staff told us they did not read the care plans and relied on gathering information by word of mouth from other staff. A system of staff shift handover recording was used to pass on information about people's needs to the incoming staff team. The effectiveness and reliability of these as a guide for staff to follow was questionable as five of the six handover record sheets we looked at for the day of the inspection were incorrectly dated. We also found people and their relatives were not always aware people had a care plan although we noted these were held in people's rooms so staff and people could access them.

The service had a staff team who provided activities for people. These included craft sessions, singing and outings. People and some of their relatives said they were satisfied with the activities being provided. However, one relative told us there were periods when no activities were provided. We observed the activities took place in a central location and that on one unit where people who were living with dementia resided there was no activities over two days. Staff were observed to support people by engaging with them and involving them in watching DVD movies but were too busy with other care tasks to sustain this. The home's management acknowledged this was an area they needed to address. We found that the registered person had not maintained people's welfare and well - being by providing adequate activities for people. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's management team told us complaints and concerns had not been properly addressed. They were unsure how many complaints had been made and were in the process of looking into each of them so they were investigated and addressed. It was not known if there were nine or eleven complaints made since June 2014. We looked at the records of complaints made to the provider by relatives. For one of these, where the relative said they had not received a response to their complaint, there was a record that the provider looked into the complaint in November 2014 but there was no response to the relative about this. We also saw records of communication where the relative had made enquiries as to why they had not

Inadequate

Is the service responsive?

received a response to their complaint. There was a record of the provider requesting a meeting with the relative in February 2015, which was some thre months after the complaint was made. We also saw another record of a complaint made in January 2015. There was a record of a telephone conversation with the complainant but this did not include any details or the name of the staff member who spoke with the complainant. There were no other records about how this complaint was dealt with.

The Commission received a complaint about the home and wrote to the provider to ask them to look into the concerns and to respond by a certain date. A response was not provided and further approaches to the provider were required before we received a full response to the issues raised. One of these concerned a lack of security in the home. The provider failed to look into this in the timescales we asked. In the meantime there had been a breach of security which had a detrimental impact on the dignity of one of the people who lived at the home. The provider had failed to assess or reduce the impact of unsafe or inappropriate care or treatment as the system for identifying, receiving, handling and responding to complaints was inadequate. This was in breach of Regulation 19 of The Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People and their relatives expressed concern about the changes in both the management structure in the home, and in the lack of management direction. This included staff not being adequately supervised to ensure people's care needs were met. Relatives did say they had opportunities to give their views and were able to raise concerns at the regular relatives' meetings. However, relatives said there were basic communication problems with the management with messages not being passed on or responded to. This included complaints not being acknowledged, responded to or looked into. One relative, however, told us they considered the home was well managed and another relative made positive comments about the effectiveness of the home's clinical lead registered nurse.

The home was not well managed. The acting manager had left a few days before the inspection and there was no acting manager to replace them. The provider's regional managers were present on the days we inspected to provide direction and support. They told us there were considerable problems with the way the home had been managed and were attempting to address these. Following our inspection we gave verbal feedback to the provider about our findings. They provided an improvement plan of how the home was to be managed and run, and how they were to address our findings when concluded.

We found the home's systems and organisation, as well as communication between managers and staff, were often dysfunctional. For example, a continuing health care registered nurse told us how they posted an application form for staff to complete regarding someone's eligibility for continuing care funding. They told us the letter was not opened by staff at the home until 20 days after it was posted. This meant there was an unnecessary delay in the person's funding application.

Whilst we saw examples of staff demonstrating compassion and respect for people we also found staff did not always respond to people's needs to keep them safe. There was a lack of management presence and direction to check staff were working in accordance with decisions made by managers and that staff were meeting people's needs. For example, in one unit staff had decided to reduce staffing levels by one staff member by moving the staff member to another unit. This was contrary to the decision made by the management team regarding safe staffing levels needed in this unit. The home's management were unaware of this change in staffing when we brought it to their attention which had the potential impact that the staffing levels in this unit would be unable to keep people safe.

Communication between staff and the home's management was poor. Advice and guidance from health care professionals was not acted on and staff had failed to record and pass on important information. The home's management had failed to monitor care needs to the extent people were either at risk or had experienced a lack of care resulting in injury. Staff were moved from unit to unit and we found many staff did not know the care needs of those they were looking after as they said they usually worked in another unit in the home.

The provider failed to investigate concerns raised with them by staff as well as by the Care Quality Commission which placed people at risk of harm. Communication and interaction with people's relatives was frequently lacking in transparency with complaints not responded to. Providers are required to send notifications to the Commission regarding specific incidents in the home and to inform social services of any allegations or concerns about people's safety that fall within the definition of safeguarding incidents. We found examples where this had not occurred.

The provider had not monitored those people on a Deprivation of Liberty Safeguards (DoLS) authorisation and had not applied to renew one person's DoLS which meant the person was not lawfully supported in having their liberty restricted.

The provider used a number of systems to audit the service. We saw one audit by the provider highlighted that people's care plans needed to be improved. The provider's process of monitoring and checking the governance and operation of the home were inadequate. Where audits showed errors, such as in the medicines procedures, sufficient action had not been taken to prevent it reoccurring. We found that the registered person had not protected people against the risks of receiving unsafe or inappropriate care by the operation of systems to regularly identify and manage risk to people's health and welfare as well as regularly assessing the quality of the service. This was in breach of Regulation 10 of the Health and Social

Inadequate

Is the service well-led?

Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The maintenance and security of people's records in the home did not ensure people's rights to privacy and confidentiality were adhered to. Care records were left on work stations in corridors and were not always securely stored when not in use. Basic recording about people's needs was flawed to the extent this had the potential to affect the care people received. One registered nurse was unable to access the computer records and it was unclear how they accessed the care plans and recorded information about people's care. Agency nurses were not provided with their own log on IDs to access and record care records but were using other staff's which meant records were made under another staff member's name. Handover sheets were used for staff to record information about people's individual care needs so the incoming staff shift had the details they needed to provide care. These were incorrectly dated for five of the six units and the clinical lead registered nurse was unsure which date they referred to. Some of the handover sheets shown to us for the day of the inspection had dates of between three and eight months previous. We found that the registered person had not protected people against the risks of receiving unsafe or inappropriate care by maintaining accurate and secure records. This was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not made arrangements for obtaining, and acting in accordance with, the consent of service users in relation to their care and treatment. Service user's consent had not been sought for specific procedures. The registered provider had not reviewed and reapplied for the renewal of a service user's Deprivation of Liberty Safeguards authorisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably, qualified, skilled and experienced staff were not employed at all times. Staffing was not provided as assessed as being needed to meet service users' needs. At meal times there were insufficient staff to meet service users' needs. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive adequate training, supervision and appraisal so they were supported to enable them to provide care and treatment to an appropriate standard. There was a lack of training for newly appointed staff and a lack of appraisal they were competent to provide safe care. Staff were not provided with adequate training and supervision. Regulation 18 (2)

Regulated activity	Regulation

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured people were protected against the risks of inappropriate care and treatment arising from the maintenance of accurate records. Records were not securely stored. Records were incorrectly dated. Staff, including registered nurses, did not always have access to the home's computerised records. Regulation 17(2) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not responded to allegations of abuse. This included a failure to look into concerns and to make referrals to the local authority. Regulation 13 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not ensured the welfare of people by providing adequate day time activities. Regulation 9 (1) (3) (a) (b).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe as arrangements for care as advised by health care professionals was not followed. People's care was not properly assessed nor care plans devised to show how care was to be provided. Staff were carrying care procedures which were not recorded in care plans and equipment was not provided to keep people safe as identified in care plans. Regulation 9 (1) (a) (b) (i) (ii) (iii) and (iv).

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 16 April 2015. A further inspection will be carried out to ensure the provider has met the requirements of this notice in due course.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines. Service users did not always get their pain relief medicines and care plans did not always include guidance for staff to follow when people needed medicines 'as required.' Regulation 13 (1) (2).

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 16 April 2015. A further inspection will be carried out to ensure the provider has met the requirements of this notice in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

This section is primarily information for the provider

Enforcement actions

The registered person had not ensured complaints were fully investigated and, so far as reasonably practicable, resolved to the satisfaction of the service user or the person acting on their behalf.

The registered person had not taken steps to coordinate a response to complaints where that complaint related to the care or treatment of a service user or where the provision of such care was shared with others. Regulation 19 (1) (2) (c) (d).

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 16 April 2015. A further inspection will be carried out to ensure the provider has met the requirements of this notice in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person had not assessed and monitored the quality of the services provided and had not assessed and managed the risks to the health, welfare and safety of service users. The registered person had not operated an effective system which had regard to complaints and comments and investigations in relation to the conduct of staff, records and professional advice. Regulation 10 (1) (a) (b) (2) (a) (b) (i) (ii) (iii) (iv).

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 16 April 2015. A further inspection will be carried out to ensure the provider has met the requirements of this notice in due course.