Queensland Care Limited

The Pines Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service over two days on 5 and 8 January 2016. The first day of the inspection was unannounced.

At our last inspection on 22 September 2015 we identified continued breaches of legal requirements in relation to the care and welfare of service users, staffing levels and staff training, which impacted on staff ability to provide safe, consistent care. Audit and quality assurance systems had not been effective in identifying and addressing problems.

The Pines Care Home provides personal care and accommodation for up to 30 older people. Accommodation is provided over four floors, which are accessible by passenger lift. There are a range of communal facilities including two lounges, a dining room, conservatory and an enclosed garden area. When we inspected the service was providing care to 13 people who were all accommodated on the lower ground and ground floors.

At this inspection we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and the governance and leadership of the service. We also found shortfalls in staffing, person centred care and the environment.

The service did not have an operational registered manager in place. A registered manager is a person who has registered with the 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.

We found that processes were not robust and safeguarding processes had revealed that people had not always been protected from the risk of harm. The provider had failed to take appropriate action to identify risks to and manage those risks to ensure people's safety. There was an inexperienced management team and staff were not being deployed effectively to meet people's care needs safely. Staffing levels were not assessed against the dependency levels of people using the service. We were told staffing had been reduced because the service was running on low occupancy levels. However we observed periods of time when staff were trying to support people with a variety of tasks. This meant staff were rushed and people did not experience good care.

The environment was not safe or suitable for people living with dementia because it had the potential to increase disorientation and there was little in the way of dementia friendly prompts and signage. There were some uneven areas in the corridor floor on both the lower and ground floors which could pose potential difficulties for people with dementia or mobility problems.

Care staff had not received the training and support they needed to be able to deliver effective person centred care for people who used the service. We observed examples of poor care practice, including the

way that medicines were being handled, which placed people at further risk of receiving unsafe or inappropriate care.

People were not supported to maintain their nutrition and ongoing healthcare needs in a timely way. We witnessed examples of unacceptable staff practices where we had to intervene to make sure people were supported to eat and drink or take their medicines in a safe way. We also had to prompt staff to seek medical input for some people. Overall we had to refer six people to the Local Authority safeguarding adults teams as a result of our findings and concerns over people's welfare. We will continue to monitor these and liaise with the local authority as needed.

We received negative feedback and observed that not all staff were caring towards the people they were supporting. We observed curt and uncaring attitudes and verbal responses from care workers who were clearly not trained or supervised in how to provide good customer care. People were not routinely involved in decisions about their care. People felt that concerns were not listened to or acted upon. People's preferences were not always taken into account when staff were delivering their care.

The provider had failed to put effective systems in place to gather the views of what people felt about the quality of the service. The systems in place designed to identify and bring about improvements in the service were ineffective.

We had to ask the provider to take urgent steps to ensure people's safety during the inspection which mainly involved improvements to staffing, people's safety and welfare and management.

As a result of the amount and seriousness of the regulatory breaches we are currently following our enforcement procedures and will report on this once completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This service will continue to be kept under review and, where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Appropriate systems were not in place to protect people. Risks to people were not always identified and acted upon.

Staffing levels were not sufficient to meet the needs of people who used the service and safe medicines management procedures were not safe.

Staff were recruited by safe recruitment procedures.

Is the service effective?

Inadequate

The service was not effective.

People were not supported with their ongoing healthcare needs.

The requirements of the Mental Capacity Act 2005 were not being adhered to which meant that people's rights were not protected.

People's weight and fluid intake was not being adequately monitored. We received positive feedback about the chef however we observed that people's mealtimes were poorly organised and received negative comments about the quality of the food.

Staff were not appropriately trained and supervised to provide care and support to people who used the service.

Is the service caring?

Inadequate

The service was not caring.

We received negative feedback about the quality of care and observed that not all staff were caring or respectful towards the people they were supporting.

Some people told us individual staff treated them well. However, we observed poor staff interactions and instances where people were not treated with dignity and respect throughout the inspection.

We observed care was task focused and did not see a consistently kind or warm approach from all care staff. People's basic care needs were not being maintained and some people looked unkempt in their personal appearance.

Is the service responsive?

Inadequate

The service was not responsive.

People's preferences were not always reflected in care plans or acted upon by staff.

People told us that staff had not acted upon concerns raised with them including concerns about people's changing health care needs.

Staff had not always followed advice given by external health professionals which placed people at risk of receiving inappropriate or unsafe care.

There was an inconsistent approach to providing social activities and we saw some people received very little social interaction or stimulation.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in charge of the service.

There was inconsistent leadership and management. People were not clear about the management arrangements and reported a lack of confidence in staff.

Effective management systems were not in place to protect people and promote their safety.

The lack of management oversight had resulted in deterioration in the quality of care people were receiving and placed people at risk of harm.

Appropriate systems were not in place to effectively engage with people and relatives to gain their views in the running of the service.

The Pines Care Home

Detailed findings

Background to this inspection

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

This inspection took place over two days on 5 and 8 January 2016. The first day of the inspection was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor who was a registered nurse with experience of nursing care of older people and an expert by experience. The expert by experience had experience of caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the service. This included the action plan, which the provider had submitted following inspections in January and September 2015. We reviewed information we had received about the service and notifications that the provider had submitted. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned as requested.

We contacted North Yorkshire local authority and Healthwatch. This organisation represents the views of local people in how their health and social care services are provided. This information was reviewed and used to assist with our inspection.

During the inspection we spoke with 13 people who used the service, four visitors and a visiting GP. We observed the staff handover from the night care staff to day staff.

Throughout the inspection we also spent time with people in the communal areas of the home and in their rooms observing how staff interacted with people and supported them. We observed the mealtime experience and a member of the inspection team shared a meal with people.
We spoke with the operations manager, area manager, deputy manager and all the care staff present. We also spoke with the cook, administrator, maintenance person and the domestic.

We reviewed electronic records for three members of staff and care records for nine people. We checked the records relating to the management of the home such as training records, maintenance records and quality assurance audits and reports.

Inadequate

Is the service safe?

Our findings

At the last comprehensive inspection on 28 January and 11 February 2015 we found that staff were not always provided in sufficient numbers or appropriately deployed to support people in a timely way and to ensure that people's care needs were met.

After the inspection the provider told us that they would complete a dependency analysis by the end of June 2015, which they would then use to make sure adequate staffing levels were maintained.

At the focused inspection on 22 September 2015 the new manager told us that they had increased the staffing levels and said this had improved their ability to provide safe, reliable care. However, staff rotas showed that these levels of staffing were not consistent over time and improved staffing levels had not yet been fully established to meet the needs of the people who used the service.

At this inspection we found people were not provided with dignified care because of inadequate staffing numbers and deployment of staff. We reviewed the rotas for the last two months and saw high levels of sickness, staff absence and a reliance on agency cover. We observed periods of time when there was inadequate staff supervision to ensure people were safe. Relatives told us that they were concerned there were not enough staff at the service to meet people's needs and keep them safe. One person said," [My relative] is left by herself in the downstairs lounge for hours." Another person who used the service told us they sometimes had to go to the toilet in their continence pads as staff could not always respond to bells quickly if they were busy. This meant people's dignity was not met because the service did not have sufficient staff available to support people.

The deputy said they felt that there were sufficient staff for the number of people accommodated at the time. They told us that a reduction in staff hours had been based on the occupancy levels; this demonstrated the provider had assessed the number of staff required based on the number of people but had not taken into account people's individual care needs.

These matters were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing.

When we looked how the risks to people's health and safety had been assessed we found risk assessments were not reviewed or updated in response to people's changing needs. This meant people were at risk of receiving unsafe or inappropriate care. Care staff were unclear about safeguarding issues and had limited knowledge and understanding of what constituted a safeguarding concern and local safeguarding protocols. We saw there had been incidents within the service which had not been reported such as unexplained bruising. This meant we could not be assured that incidents had been properly investigated. We made a total of seven safeguarding referrals to the local authority which were identified in relation to six people's care needs not being met, staff not following nutritional assessments and poor care practice.

We observed a senior member of care staff attempt to administer one person's medicines when they were

asleep. The member of care staff repeatedly said the person's name in an attempt to rouse them; they removed the person's glasses and touched their leg. But the person did not wake up. Another person who used the service commented, "She's been like this all morning." Despite this the member of staff attempted to spoon the medicine directly into the person's mouth, followed by a drink. When they tried to give the person another drink they spat it out and looked distressed. This was not an acceptable or safe way to administer medicines and left the person at risk of harm. We spoke with the deputy immediately to raise our concerns, they agreed to investigate the matter.

We saw one person, sat in a communal lounge, looked uncomfortable. We asked them if they were okay and they showed us their groin area, which was red and inflamed. The person told us it had been irritating them. We raised this issue with the operations manager and the deputy to ensure the person received the appropriate support and medical attention. On the second day of the inspection a senior care worker told us that the person had not seen a GP since our visit and they were not aware of any concerns in relation to the person's skin. This person was assisted with their personal care and we were concerned this issue had not been identified by care staff who supported them. We checked the care records and saw no reference to the concern we had raised. The member of staff we spoke with said the person received their personal care by the night staff and no concerns had been shared at the handover. Records confirmed this. This meant that people were at risk of harm because they were not receiving the care and support they needed in good time.

We asked the operations manager why the person had not had medical treatment earlier and they told us that the senior staff had been made aware. Before leaving the home on the second day we confirmed that the GP had visited and prescribed a topical medicine for the person's use. We made two safeguarding referrals to the local authority in relation to concerns about this person's care.

One person remained in their bedroom, they were living with dementia and could not use the call system to summon assistance. Records showed that staff were not undertaking hourly checks in line with the person's care plan. Their room smelled unpleasant and they remained in their nightwear throughout the day. The daily record stated that they were 'verbally and physically aggressive' at times and had been resistant to personal care on six occasions in the past two weeks. We saw the person's risk assessment and care plan had not been updated and staff told us that they had not been referred to the GP or the mental community health team for further advice.

When asked about this person's care needs a care worker said, "First thing on a morning change her, change pad and get her out of the bedroom." We asked about this person's care needs and they said the person could be, "Physically aggressive" when being showered. They were not able to tell us how they could act to reduce the person's distress and our observation on the day would indicated that a number of staff were not sufficiently skilled to be able to do so. Another member of staff said, "I don't use the care plans often, that's more for the senior to do.

We found the risk assessment process was not effective as risks were not regularly assessed and actions taken to minimise the risk reviewed.

Although care records contained risk assessments these were not being reviewed and updated in a timely way. Individual accident record forms showed 19 falls were recorded between October 2015 and January 2016, and 16 of these were unwitnessed falls. For one person we saw they had suffered unwitnessed falls on 8 October and19 November 2015. There was no evidence to show that the incidence of falls for this person had been analysed and action taken to try to reduce or prevent reoccurrences. This person was subsequently admitted to hospital with a serious injury following another unwitnessed fall on 24 November 2015.

We saw another person was assessed as being at a high risk of falls and had at least five falls over a one month period. The person's record on 26 December 2015 stated," [Name] has had to have bed railing put up for safety as they kept lying on the floor." Although the use of bed rails was recorded in their care records, a risk assessment was not in place. The deputy confirmed the decision to use bed rails had been made without any district nurse or occupational therapy involvement and they had not considered alternative options for keeping the person safe and whether the use of bed rails was appropriate.

This person's care plan had not been reviewed following falls even though they had sustained two skin tears on 4 January 2016 that necessitated urgent hospital attention. We observed they were left unsupervised on numerous occasions and on at least one occasion we observed them walking without their walking frame and had to assist them to sit down safely. At another time we saw the person walk towards an unfixed radiator cover that was placed lengthways against a wall. This was brought to the attention of the operations manager and the cover was subsequently moved. This meant that without our intervention this person was being placed at potential risk of injury through further falls.

On the first day of our inspection we observed the connection lead for one person's call bell was not attached to the wall so it could not be used to call for staff assistance. The deputy told us this person could use the call bell to summon assistance, which added to the impact on the individual's well-being. On the second day we found the call bell was not fully inserted into the wall. We tested the bell and found that there was an intermittent fault which left the bell ringing on some occasions after it was cancelled. Following our visit the operations manager confirmed that an electrician had completed a full assessment of the call system and found it to be in full working order. They were conducting further investigations into why the call bell had been disconnected.

We checked the arrangements for the management and administration of medicines. In reviewing a random sample of Medication Administration Records (MARs) it was noted that two people's medicines had not been recorded as administered. A visitor told us they had witnessed staff leaving medicine beside their relative but with no encouragement to drink it. They said, "If I hadn't been there it would be left and [Name] wouldn't have taken the medicine." We discovered one person's dispersible medicine in a cup by the side of a chair at 3.45pm. in a communal area. We spoke with the operations manager who removed the medicine. This demonstrated unsafe techniques in relation to medicines; the person whose medicine it was had not taken it in it line with the prescribing instructions. In addition to this it was left in a communal area, which was used for people living with dementia. This meant it could have been taken by another person in error.

We checked the controlled drugs cupboard with the operation manager and we saw that it contained controlled drugs, which were no longer needed. This meant that staff were not following best practice guidance around the management of controlled drugs, which are subject to stricter controls. Medicine audits were not being carried out at regular intervals, which meant the provider did not have safe systems in place to ensure any issues were found and put right in a timely manner.

All of the above matters were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

The local authority had alerted us to issues in regard to staff recruitment practices following their last visit to the home in October 2015. The operations manager told us that action had been taken to ensure that recruitment checks were in place before staff started work at the home. The manager was now required to confirm all of the required checks had been undertaken before head office authorisation was given for staff to begin work. We viewed personnel files for three care staff and saw they had been subject to a minimum of two references, and a Disclosure and Barring (DBS) check had been carried out before they started in their

roles. A DBS check provides information about any criminal convictions a person may have and is used to help providers make safer recruitment decisions.

Inadequate

Is the service effective?

Our findings

At the last comprehensive inspection on 28 January and 11 February 2015 we found that care staff lacked the necessary knowledge and skills to be able to provide effective care for people living with dementia.

After the comprehensive inspection the provider told us that they had completed a training needs analysis which had highlighted staff training needs.

When we inspected on 22 September 2015 the manager showed us training files, which had been compiled for each member of staff. However, these contained blank forms only and staff had not completed their self-assessments as the provider had said in their action plan.

At this inspection we found staff were not receiving the appropriate support and training to carry out their duties safely.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that staff were unclear about their responsibilities in regard to MCA and DoLS.
When asked about the level of supervision people required a member of staff told us, "No one would be allowed to leave, everyone is on two hourly checks." The local authority confirmed that they had received two applications for DoLS with regard to the use of bed rails. This meant that people's liberty was being restricted without the required applications to a 'Supervisory Body' for authority to do so.

Based on our observations we did not think all of the staff who worked at the service had the skills to deliver effective care to people living with dementia. The deputy told us that one person talked constantly and this could irritate other people who lived at the home. We observed that staff did not make any attempt to interact with the person to divert their attention which could have helped to reduce people's irritation. We heard them say to staff, "I get confused, where am I? It's the Alzheimer's." The senior care staff they were speaking with responded, "Oh well," which was not a caring or helpful response and the person was not offered any reassurance.

When we asked for sight of staff induction records the deputy showed us the individual staff folders again but the self-assessments had still not been completed. We saw an induction record for one member of staff but this had been undertaken by a manager at another service and not all of the information was relevant to this service. We were told by two care workers that there was no opportunity to shadow more experienced colleagues when they started work as new staff were included in the staffing numbers.

Staff had not received structured supervision on a regular basis and a staff meeting held in November 2015 stated that planned training on the Care Certificate had been put on hold while other training was sourced. The operations manager shared the training matrix which showed that staff required updated training in a range of issues including health and safety topics such as fire safety and first aid. There was a lack of clarity regarding the frequency of competency checks carried out for staff undertaking the administration of medicines. This meant the provider could not be assured staff responsible for the administration of medicines were competent. When we visited again the operations manager gave us another staff matrix, which they said the area manager had updated, which showed that staff training was in progress. However, we found that the provider had failed to act on previous requirements in regard to staff training and support, to ensure people received care from sufficiently skilled and competent staff

These matters were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing.

At this inspection, we found that people's ongoing health needs were not managed effectively. One visitor told us they were concerned about a lack of appropriate response from care staff in relation to their relative. They had raised concerns with a member of care staff about their relative losing weight and that they had back pain. However, they were not confident that effective action would be taken. They said, "It could be a couple of days, there's no sense of urgency with them. I have insisted they ring today because she is in pain." We checked the person's care plan which stated that the person should be weighed weekly and confirmed weekly weights were not being done. Food and fluid charts were not completed fully despite the person having complex health care needs and assessed as being at nutritional risk.

Discussion with the senior care worker revealed a lack of understanding regarding nutritional and fluid intake. Whilst intake charts were being recorded we were not confident that staff fully appreciated what they were recording, and what actions to take in relation to poor intake. Records did not provide an accurate description of people's intake and we saw numerous records of '200mls', which staff said recorded the amount they were offered and not the amount taken. For one person care staff had misunderstood the dietitian's advice in regard to sips of lemonade to aid swallowing reflex. So while we saw a lemonade bottle placed next to the person they were not being encouraged to take sips 20 minutes prior to eating as advised. A safeguarding referral was made in relation to this concern.

For another person their records noted a loss in weight from 39kg to 36kg, which was 10% of their body weight. A care worker told us where possible people were weighed regularly but said that sometimes they could not weigh people accurately and 'guessed' at an approximate weight. This meant that people's changing needs might not be correctly identified in a timely way. A relative said, "[Name's] hands shake and can't hold a cup without spilling it. I had to ask to staff for a special mug that allows [name] to drink safely and enjoy their drink. I shouldn't have to ask staff this kind of thing. They should see it and sort it out themselves."

One person had diabetes and it was unclear from care records how their condition should be monitored. This meant that there was a potential risk that staff would not effectively monitor their condition to identify changes which may affect their health

Recent safeguarding investigations had concluded that staff did not always act upon the advice of healthcare professionals in repositioning people and providing pressure area care. We looked at the care records for people assessed to be at risk of skin damage. Records showed that people were not receiving positional care in line with care plans. This left people's skin integrity at risk, which placed people at potential risk of harm.

These matters were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe and proper care.

We received positive feedback in regard to the chef. One person said they were, "Fantastic" and another said they went out of their way to be helpful. One person said, "I always get a good meal." The chef told us that two people were celebrating their birthdays and they had made a special cake for each of them to enjoy.

Despite this we received negative feedback on the quality of the food and most people left between a third and two thirds of their meals. Comments included, "It's tough" and, "I can't chew it." Another person said, "I'm not keen on the dinners. I don't like gravy or the potatoes. I just have tomato soup. " Lunch consisted of a main course with a choice of either beef in a sauce or pork fillet served with potato wedges or mashed potatoes, broccoli and swede. A dessert of bread and butter pudding or mousse was offered. We saw the care staff trying to tell individual people about their choices of main and dessert courses. Because of their complex care needs it was evident that people could not grasp the choices on offer. Staff could have shown people a plate of each main and each dessert dish to choose from, which may have helped the people make a more informed choice.

The general layout of the lower ground floor area did not provide a pleasant or therapeutic environment for people living with dementia. This floor houses the service areas of the home, kitchen, boiler room, laundry and several store rooms as well as bedrooms. For people living with dementia it had the potential to increase disorientation and there was little in the way of dementia friendly prompts and signage. Bedroom door name signage was relatively small, and there was no door /door frame colour differentiation to assist people with dementia to recognise individual bedrooms and toilets. A small lounge / conservatory area on the lower ground floor was used once for a short time by one person but there was nothing to stimulate the person or allow them to interact with the environment. We saw one person was wandering all day and they repeatedly trying locked doors. Again we found that they had no meaningful stimulation and nothing to interact with.

Whilst it is acknowledged that the building is old, there were some uneven areas in the corridor floor on both the lower and ground floors which could pose potential difficulties for people with dementia or mobility problems.

These matters were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Premises

Inadequate

Is the service caring?

Our findings

Before our inspection we received information about people's care needs not being met in a timely way. Concerns had been raised that people were not receiving the help they needed to eat and drink and were left unattended in dirty, wet and stained clothing.

On arrival at 7.50am on the first day we saw three people in the main lounge, two of whom were asleep. We saw a dish of porridge and the cup of tea in front of one person was cold and after the staff handover we saw a care worker clear away their untouched meal.

We observed this person at periodic intervals throughout the morning; they were sleepy and staff had difficulty in rousing them. A relative confirmed they needed staff supervision and prompting to eat and drink because of their dementia care needs. At lunchtime we saw they were struggling to manage their meal independently and they were dropping food onto their clothing. We asked the senior care worker about this person's care needs because they had not eaten. They said, "They are normally okay to manage independently, but they are not well."

The member of care staff provided support to assist the person to eat but they did so in a disrespectful way spooning food into their mouth without engaging in conversation. We saw the person looked upset and spat the food out. We found there was a risk of the person developing further problems because they were failing to eat and drink and staff were not taking suitable steps to meet their care needs.

Another person had food debris down their clothing all day and a strong smell of urine was evident both on their person and in their room. Staff confirmed the person had dementia care needs and was reluctant to get washed and changed. We looked at their care plan, which indicated that the person had shown an increased resistance to staff interventions since August 2015. Their care plan stated they had suffered from urine infections, were 'reluctant with personal care' and lacked insight into their personal care needs. Staff said that they avoided putting the person in situations which produced anxiety and distress. However, this resulted in the person staying in their room for the entire day with only minimal staff interaction. We were concerned this person's mental health needs were not being met, which placed them at risk of developing further health problems. We raised this with the operation manager who confirmed they would ensure a request for a GP referral was made in relation to this person's mental health needs.

These matters were a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 – Safe and proper care.

We found that people's care needs and personal hygiene were not maintained to a good standard and people looked unkempt. For example, three people had dirty finger nails. We checked the personal care record for one person, which indicated nail care had been given on three occasions in the days preceding our visit. Despite this record we observed their finger nails were varied in length, unfiled and dirty. Another person whose nails needed cleaning told us they had always taken a pride in their appearance and would like their nails manicured. We spoke with the deputy who was unsure why the person had not had their nail

care as they had requested. This showed us that people's previous lifestyle choices were not being considered or met.

Care plans contained limited information about people life history, future wishes and preferences. One person's care plan stated the person suffered from anxiety and needed reassurance. However, there was no guidance for staff on how the anxiety manifested itself or the action they should take to reassure the person and therefore help to reduce their anxiety. We found staffs were task orientated and we observed poor levels of interaction between the staff and people who used the service. For example, at lunchtime we observed that staff did not engage people in conversation, and we did not see staff getting down to people's eye level or offer reassurance. A relative said, "In any of my visits I've never seen any carer on their knees, at eye level, talking to, touching or holding anyone living here."

Staff did not consistently respect people's privacy. For example, a member of staff came into a person's bedroom; they did not knock and interrupted a conversation which was taking place between the person and a member of the inspection team. The member of staff was abrupt in their manner and said, "Did you ring your bell?" before checking the bell and leaving the room without further conversation, which was disrespectful.

Other people told us that they liked the service. During our visit we saw staff join in with the activity organiser to sing happy birthday for two people living at the service. We observed that the activities coordinator engaged people speaking and joking; people joined in the singing and played armchair dancing. They were lively, bubbly and enthusiastic, fun and succeeded in creating a good time for people. The people seemed to really enjoy the session. One person said, "I do pretty well. The girls are very good." Another person said, "I'm very, very happy. Everything is done for me."

We overheard one care worker talking with a person in their bedroom. The person was initially somewhat agitated and the staff member patiently reassured them and tried to gain their interest in the day ahead. They said, "If you like, later on I'll come and enjoy a cup of tea together and I'd have a chat with you. I'll come and keep a check on you." Another person said, "The staff here do a fantastic job as far as their skills go and time allows. But it's hard to find staff on this floor."

Inadequate

Is the service responsive?

Our findings

At our comprehensive inspection on 28 January and 11 February 2015 we found that people were at risk of receiving unsafe or inappropriate care because care was not always planned to meet people's individual care needs. After the comprehensive inspection the provider told us that pre-assessments had been completed and included more detail about people's life history and mental health needs.

At our focused inspection visit on 22 September 2015 we found that staff did not have the skills needed to provide safe care for people with complex health care needs. The manager at the time had raised issues with the local authority about the high level of people's care needs and dependency levels. Nine people were subsequently reassessed as requiring either general nursing care or more specialised dementia care. The local authority confirmed to us on 23 December 2015 that all of these people had transferred to new placements leaving a total of 13 people living in the service.

At this inspection we found continuing problems with effective, responsive care planning and recording. We found evidence of falls in one person's care records where accident / incident forms had not been completed. We asked the deputy why the relevant forms had not been completed and their risk assessments and care plans updated. They were unable to provide an answer. There was an inconsistent approach to assessment and planning of care, with no clear links between the care plans and the daily / night record of care. We were informed that care staff did not routinely access the main care records to look at care plans. It was noted that recent efforts have been made to summarise the information in the care folders into a one sided laminated sheet which contained key information of the individual's care needs, including observations required and direct care required. This was a useful tool, but the ones we saw required updating.

The provider had introduced a digital care record system which was being phased in. However, the only information being recorded on the system related to the day and night care provision record, and did not contain details of specific care needs. We found evidence of contradictory information entered onto separate records being kept in the home. For example, the handover notes for one person noted they were shouting out through the night but routine hourly checks recorded the person was 'asleep'.

Care plans were not person centred and contained non-specific entries such as, 'can wash independently' and, 'occasionally incontinent'. Evidence of the inconsistent approach to care was highlighted in one set of records which described a very personalised assessment. However, we found that this person had been admitted from another care home that provided specialised dementia care and this detailed information had been transferred along with the person on their admission and was not generally representative of people's care records. One visitor said, "I've had to ask the carers to interact more with [Name] but I'm not sure they have done. Though [my relative] has got dementia they can still remember things and they need to be stimulated more."

People with dementia care needs were accommodated on the lower ground floor and there was a potential

for people to become socially isolated due to lack social stimulation in this environment, as much of the activity of the home took place on the ground floor. A person who used the service said, "I am bored there is nothing to do."

The deputy told us that between September to December 2015 there had not been any activity programme provided for people living at the home. They said staff had started a programme of activities that week, which the manager and administrator had developed. The deputy told us that an independent activities coordinator had also started to work part time at the home and would be responsible for putting together a programme of activities. We asked to see the programme but the deputy told us it was not ready yet.

These matters were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person centred care

We received conflicting information about staff response to complaints. One person said to us, "The girls are very kind and I have no complaints." Other people told us that they had raised issues but were not always confident that they would be investigated thoroughly. The complaint procedure stated that complaints should be made in the first instance to the manager. However, people told us they were not clear about the current management arrangements or who to speak with in the organisation if the issues they raised were not effectively resolved.

One person who used the service told us they had complained about the behaviour of another person with dementia related care needs but nothing had changed as a result. The impact of their behaviour was evident when we visited but staff allowed it to continue unaddressed, which was an issue. Another person told us they had complained about their relative's dentures going missing. They said, "They didn't seem that concerned about it. She still hasn't got any. And we've kind of left it now too." This meant the provider had not taken action to address this concern which had been previously highlighted. We asked the deputy about complaints but they were unsure as to what action had been taken to record and investigate people's complaints. This showed the provider was not taking steps to ensure people's complaints were dealt with thoroughly.

These matters were a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – receiving and acting on complaints

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection on 28 January and 11 February 2015 we found the provider had not identified, assessed or and managed risks relating to health, welfare and safety of people who used the service or the quality of the service.

After the comprehensive inspection the provider stated a new quality management system was being devised and would be rolled out to senior managers in June 2015.

At the focused inspection in September 2015 we found that leadership was inconsistent and there was an inexperienced staff team. A new manager and area manager had been appointed. However, both had spent a limited amount of time in the home since their appointment.

At this inspection we identified significant concerns. The provider had failed to ensure that the service had developed and been improved to meet the needs and preferences of the people who used it. Staff were not consistently using the governance and risk assessment mechanisms which were in place such as reporting systems with regard to accidents and incidents in the service. . Where issues had been identified following safeguarding invesigations action had not been taken to improve the quality of the service. This had resulted in people receiving care which was inconsistent and did not meet their care needs.

The registered manager had not been working at the home since August 2015. A new manager had been appointed but had left at the end of October 2015. We found the service was reliant to a large extent on an inexperienced staff team; there was a high incidence of staff sickness and absence and these factors had all impacted on people's care, support and safety. In addition the area manager who had been providing management oversight from November 2015 was due to go on an extended period of leave.

We found ineffective management systems to monitor how incidents, allegations and complaints were acted on and this had led to people being placed at risk of harm and receiving care and support that was not safe. For example, for one person the food and fluid charts from 13 to 16 December 2015 recorded 'refused diet' on 17 occasions. Rotas showed that both the area manager and the deputy had been present in the home throughout this period.

The lack of appropriate management oversight and leadership meant that the provider had failed to identify the issues that we found, which had resulted in people not having their care needs met. Issues were identified in relation to medication storage and disposal which management were aware of but had not taken action to rectify. This showed that management systems were ineffective in identifying the improvements that were needed. We found that issues which placed people at risk of harm could have been identified and acted on before our inspection.

We observed inconsistent approaches in both care planning and delivery of care. People reported a lack of confidence in the staff team and did not feel that they had the necessary experience or expertise to respond appropriately to issues raised with them. Relatives told us that they had raised concerns with staff but these

had not been addressed. These issues included concerns regarding people's health care needs such as weight loss and falls. In these instances relatives told us they had raised issues directly with the doctor themselves.

Staff approaches to people were inconsistent, ranging from curt and potentially dismissive to sensitive and caring. This reflected a lack of effective leadership and lack of sufficient role modelling owing to the management changes. The provider was failing to ensure that staff including senior staff were properly supported to fulfil their role.

Records confirmed that that the provider had not always submitted notifications in a timely way and we identified notifications that were incomplete, inaccurate or contained contradictory information. One example of this was in regard to one person who had sustained a serious injury on 23 November 2015. This person had also suffered at least two previous unwitnessed falls. The lack of scrutiny and analysis following such incidents meant that the provider was failing to analyse incidents and accidents as they should so they could take action to prevent a reoccurrence. We also found instances of incidents and accidents that had not been picked up and reported through management systems or safeguarding processes so people could not be confident that incidents would be properly raised and investigated. One example of this was a person living with dementia who had sustained a bruised eye where no safeguarding alert had been raised.

People told us that they were not given the opportunity to have a say in how well they felt the service was being run. We found people were unclear about the management arrangements and several people referred to the manager who had left some time previously. This meant that systems to ensure that people and their relatives had the opportunity to comment and make suggestions about the running of the service did not ensure that everyone had the opportunity to contribute.

We also identified issues about the accuracy of record keeping including food and fluid charts and daily records. Staff also raised issues with us about the new recording system. They told us they needed more training on the system and we found that they had used each other's 'log ins' to enter care records. This effectively meant that care records were signed in another member of staff name (on occasion for a member of staff who was not present in the home), which meant that recording was inaccurate. We found that staff were keeping notes on separate sheets and then entering these onto the electronic record, which was duplicating their work.
We saw some records, including health care records were not stored securely or confidentially. On the first day of our inspection we observed lockable cupboards in a communal area on the ground floor were left unlocked. These contained private information of archived records and current records including district nurses records. We brought this to the attention of the operations manager. On the second day we saw that these doors were still unlocked and when we opened the door piles of loose paper fell onto the floor. This meant that confidential information could be accessed by people using the service, staff and visitors. In addition the fire safety audit had highlighted this area as inappropriate for the storage of paper records as it was a fire safety hazard. This was further evidence that the provider was not taking action to address issues in order to safeguard people living in the service, visitors and staff.
The feedback we received from relatives was largely negative. One person said, "No, I wouldn't recommend this home." Another person told us, "This is not the best or worst of homes but I wouldn't recommend it, no."
We concluded the safety and delivery of care was reliant on the individual skills of the staff team in the service. It was not based on good leadership with robust policies, systems and record keeping which would enable the provider to assure themselves they were delivering high quality care or to improve the service provided. In addition the service remained in breach of regulations which we had been assured would be addressed to improve the outcomes for people who used the service.

All of the above evidence pointed towards a lack of management oversight and leadership to take the necessary steps to bring about sustained improvements to the service

These matters were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care We concluded care was not assessed, planned or delivered in a person centred way. Care plans were difficult to follow and did not contain detailed information to enable members of care staff to know how the person should be supported. We found limited information about people's preferences, and life histories. Regulation 9 (1)(2)(3)

The enforcement action we took:

We are currently following our enforcement procedures and will report on this once completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not reviewed or updated in response to people's changing needs, which placed people at risk of receiving unsafe or inappropriate care. We concluded that care was not being managed by staff who had the necessary qualifications, competence, skills, and experience to provide care and treatment in a safe way for service users. Regulation 12(1)(2)(a)(b)(c)(g)

The enforcement action we took:

We are currently following our enforcement procedures and will report on this once completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment We concluded the environment was not suitable to provide good dementia care.

People who use services and others were not protected against the risks associated with unsafe or unsuitable premises.

Regulation 15 (1)(c)

The enforcement action we took:

We are currently following our enforcement procedures and will report on this once completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We concluded the provider had not developed an effective system to manage people's complaints and they were not acting on people's complaints. Regulation 16(1)(2)

The enforcement action we took:

We are currently following our enforcement procedures and will report on this once completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We concluded the provider had failed to put effective management systems in place to safeguard people and promote their safety and welfare. The service was not completing effective audits to ensure they could identify shortfalls in a timely way and take appropriate steps to improve the service. Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

We are currently following our enforcement procedures and will report on this once completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We concluded staff were not being deployed in sufficient numbers to provide safe, consistent care. Staff were not receiving appropriate training, supervision and support to meet people's care needs effectively.

Regulation 18 (1)(2)(a)

The enforcement action we took:

We are currently following our enforcement procedures and will report on this once completed.