Roseberry Care Centres GB

Dalewood View

Inspection report

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Ratings

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

Overall summary

As a result of concerns made to the Care Quality Commission a responsive inspection took place on 16 and 17 December 2014. This was an unannounced inspection which meant the staff and provider did not know we would be inspecting the service. The service was last inspected on 22 July 2014 and was not meeting the requirements of the regulations for care and welfare of people who use services and assessing and monitoring the quality of service provision. As a response to the last inspection the provider sent a report of the action they would take to become compliant to the Care Quality Commission. The provider informed us they would be compliant by the end of November 2014.

Dalewood View is a nursing home that provides care for up to 60 people. It is a purpose built care service. At the time of the inspection there were 54 people living at the service. The service has three floors, a lower ground floor where the service's activities room is based, the ground

Summary of findings

floor which is primarily for people requiring nursing care and the first floor which is primarily for people requiring residential care. At the time of the inspection there were seven people requiring nursing care on the first floor.

There was not a registered manager for this service in post at the time of the inspection. The current manager had been in post since August 2014, at the time of the inspection they had not made an application to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People told us they felt "safe". Some people who lived at the service had complex needs and we were not able to verbally communicate with them so they could share their views and experiences with us. Our observations did not identify any concerns regarding safeguarding of people who lived at the service. However, during the inspection we observed that one person had not been appropriately supported by a staff member and did not ensure that the welfare and safety of the person was maintained. We shared this information with the manager and the regional operations manager who assured us that they would speak with the staff member as soon as possible /immediately. Relatives spoken with felt their family member was safe and were satisfied with the quality of care their family member had received.

Most staff had received training in safeguarding vulnerable adults as part of their induction training. Our discussions with staff told us they were aware of how to raise any safeguarding concerns.

People told us they were treated with dignity and respect and this was supported by their relatives, but this was not always supported by our findings/observations. For example, we observed two staff entering rooms without knocking on doors and one staff not ensuring the doors were closed whilst providing personal care.

We observed that the interaction and communication between staff and people was mainly focussed around completing tasks. The service had an activities worker who provided a range of activities for people to participate in. People spoken with who joined in the activities told us they enjoyed participating in them.

We found the service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. This meant people were cared for by suitably qualified staff who had been assessed as suitable to work at the service.

Individual risk assessments were completed for people so that identifiable risks were managed effectively. However, we found one person's risk assessment had not been reviewed after sustaining a fall.

There was evidence in peoples care plans of involvement from other professionals such as doctors, opticians, tissue viability nurses and speech and language practitioners.

Although people's preferences and dietary needs were being met, we found the arrangements to ensure people received support with eating and drinking could be improved.

Staff received induction training suitable for their roles when they started employment at the service. However, we found that staff had not completed training in some areas of training relevant to their role. For example, one staff member had started working at the service in June 2014. The spreadsheet and their training records showed that they had not completed training in the following areas: food hygiene, moving and handling and health and safety. Staff had not received regular supervisions and appraisals, which meant their performance was not formally monitored and areas for improvement may not have been identified.

There was a complaint's process in place in the service, people and/or their representative's concerns had been investigated and action taken to address their concerns.

Meetings and completed surveys had been held with people living at the service and/or their relatives or representative. This meant people and/or their relatives or representatives did have opportunities to be kept informed about information relevant to them. We found examples where people and relative's views and

Summary of findings

suggestion had resulted in changes in the service. However, we found examples where their views and experiences had been sought and no action plan had been completed.

Our findings demonstrated the provider had not ensured there were effective systems in place to monitor and improve the quality of the service provided. This meant they were not meeting the requirements to protect people from the risk and unsafe care by effectively assessing and monitoring the service being provided.

We saw evidence that checks were undertaken of the premises and equipment and action was taken to ensure peoples safety.

We found five 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 the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People told us they felt "safe". Staff were aware of how to raise any safeguarding issues if they were concerned

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. This meant people were cared for by suitably qualified staff who had been assessed as suitable to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective. We found there was not a robust system in place to ensure staff completed all the training relevant to their role. Therefore staff had not been supported to deliver care and treatment safely to an appropriate standard.

The service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The new manager told us they had recently completed training in DoLS. However, we found only nine staff had completed training in MCA 2005 and DoLS. The manager informed us they were liaising with the local authority regarding any requirements regarding DoLS applications.

People's dietary needs were accommodated. However, we found the arrangements in place for the people who needed support with eating and drinking could be improved.

Is the service caring?

Requires Improvement

The service was not always caring. During the inspection we observed the interaction between care staff and people was mainly centred around tasks. We saw some examples where people were not treated with consideration or respect.

People and relatives made positive comments about the staff and people told us they were treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive. We found some people did not have access to a call bell to call for assistance when they needed it.

At our last inspection we found the provider had not ensured that all the people living at the service had safe and appropriate care and support to meet their needs. At this inspection we found the provider was in continued breach.

Summary of findings

We found the service had responded to people's and/or their representative's concerns and taken action to address any issues raised.

Is the service well-led?

Inadequate

The service was not well-led. There was not a registered manager for this service in post at the time of the inspection. The current manager had been in post since August 2014, at the time of the inspection they had not made an application to register.

At the last inspection we found the checks completed by the operations manager, manager to assess and improve the quality of the service were not effective to ensure people were protected against the risk of inappropriate or unsafe care. At this inspection we found the provider was in continued breach.

People's and/or their representatives views had been actively sought to enable people to share their experience of their care. However, we found that action was not always taken in response to these views or experiences.

Dalewood View

Detailed findings

Background to this inspection

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

A responsive inspection took place on 16 and 17 December 2014 due to concerns raised by an external healthcare professional to the Care Quality Commission. This was an unannounced inspection which meant the staff and the provider did not know we would be visiting. The inspection team consisted of two adult social care inspectors and a specialist advisor. The specialist advisor was a registered nurse who was experienced in the care of older people.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from the local authority. We also spoke with one external healthcare professional and a social worker.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We spoke with twelve people living at the service, three relatives, the manager, the regional operations manager, two nurses, two care assistants, a domestic worker, an administrator and the cook. On the first day of the inspection we also spoke with a manager from another of the provider's homes who was providing cover whilst the manager was on annual leave. We looked round different areas of the service; the communal areas, the kitchen, bathroom, toilets and with permission where able, some people's rooms. We used a formal method to observe people which is known as the Short Observational Framework for Inspection (SOFI). This involved us observing people who use services for a period of time and recording their experiences at regular intervals. We reviewed a range of records including the following: six people's care records, six people's medication administration records, three people's personal financial transaction records, three staff files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People spoken with told us they felt 'safe' and had no worries or concerns. Their comments included: "I've got no concerns and if I had I would go to the office and "it makes me feel comfortable knowing I can call somebody [staff]". Relatives spoken with felt their family member was in a safe place. Relatives comments included: "I feel it is a safe place" and "it is very clean, there is good security at the home for people coming in".

We found that some people who lived at the service had complex needs and we were not able to verbally communicate with them so they could share their views and experiences with us. From our observations we did not identify any concerns regarding safeguarding of people who lived at the service. However, during the inspection we observed that one person had not been appropriately supported by a staff member to ensure that their welfare and safety was maintained. We shared this information with the manager and the regional operations manager who assured us that they would speak with the staff member concerned as soon as possible /immediately.

We found that regular dependency assessments were being completed by the manager. This is a tool manager's use to calculate the number of staff they need on each shift, to identify for them the numbers of staff and the range of skills needed to ensure people receive appropriate care. For example, the number of nurses and number of care assistants for each unit. However, our observations during the inspection showed that some people's needs were not being met in a timely manner and with consideration. For example, we observed three people repeatedly requesting support in one of the dining rooms. One person told us they had been sat there since they got up and wanted support to go to the lounge. Another person asked to be repositioned in their wheelchair as they had slipped down. There was a kitchen assistant in the dining room who explained to people that they could not provide this type of support. We observed care assistants entering and exiting the dining room focussing their attention on collecting drinks and breakfasts to take to people in their rooms and not attending to those people's needs. During the inspection some of the care staff spoken with raised concerns regarding the staffing levels within the home and being able to meet people needs. We shared our observations with the manager and the regional operations manager.

During the inspection we observed staff administering medication to people living at the service. We saw that staff had a patient approach whilst supporting people. However, we observed a nurse leave a person with their tablets spread on a tray in front of them whilst they went to answer the telephone. Although this may be the person's preferred method to take their tablets it is important that staff are present to provide support if required and to ascertain whether the person has taken their medication.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs). We identified some concerns in the sample of MARs checked. For example one person had been prescribed an anticoagulant; this medicine is used to increase the time it takes your blood to clot. We found that staff had failed to record on the MAR sheet that the medicine had been administered on one occasion on the 28th November 2014. It is important that staff accurately record when they have administered medication to ensure people are given their prescribed medicines safely and consistently. The medication error had not been reported by staff so that appropriate action could be taken. For example, contacting the person's GP for advice. It is important that staff report errors to ensure that the safety and welfare of individuals is maintained at all times. We spoke with the regional operations manager who told us they would speak with staff member regarding the omission and reporting errors.

We found the arrangements in place did not ensure medicines which needed to be given at specific times with regards to food were given at the right times. For example, one medicine needed to be taken a minimum of thirty minutes before eating for best effect. It is important that arrangements are made to give medicines at the right times so that they work effectively.

Two people had been prescribed a cream. We found that topical cream charts were not being used to ensure the cream was administered correctly. A topical cream chart tells staff where a cream needs to be applied. Staff told us the creams had been administered. However, without

Is the service safe?

these charts being in place we were unable to ascertain whether the creams were being administered correctly. The two people who had been prescribed the cream were unable to tell us.

In people's medication records we saw there was information 'a protocol' to follow about medicines when they had been prescribed medication to be given 'when required' (prn). The protocols help staff ensure people are given their prescribed medicines safely and consistently. However, we found the information needed to be tailored more for the individual.

Some people in the service were prescribed a nutritional drink supplement. We reviewed two people's medication administration records and found that the two people were not being given the supplement consistently following the guidance of the GP. We also found there wasn't a robust system in place to record the amount of the supplement people had drunk to enable the GP to ascertain how effective the treatment was.

On the second day of the inspection the local GP was visiting the service. They identified that a person's medication to alleviate pain had run out and not been reordered by a staff member. This resulted in a prescription being written by the GP and a staff member going to the pharmacy to obtain the medication. It is important that robust procedures are in place to ensure that there is an adequate supply of medicines in place for people.

We found people were not protected from the risks associated with medicines because the service did not have appropriate arrangements in place to manage medicines. These findings evidenced a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at people's care records. People had individual risk assessments in place so that staff could identify and manage any risks appropriately. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. We found one person's fall risk assessment had not been reviewed after they returned from hospital after sustaining a fall. This meant the measures in place may not effectively reduce the risk of a reoccurrence.

We reviewed the staff recruitment records for three staff members. The records contained a range of information including the following: application form, interview records, Disclosure and Barring Service (DBS) check, references and employment contract. We also saw evidence where applicable that the nurse's Nursing and Midwifery Council (NMC) registration had been checked. This told us that people were cared for by staff who had been assessed as being suitable to work at the service.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. We saw the service had a copy of the local authority safeguarding adult's protocols to follow to report any events and safeguard people from harm. The staff handbook contained a range of information for staff including the following: use of media, gifts and gratuities. It was clear from discussions with staff that they were aware of how to raise any safeguarding issues.

We spoke with the administrator at the service; they showed us the provider's care service software management system to manage people's personal allowances. The administrator told us the provider paid for any expenditure. For example, for the hairdresser or the chiropodist. We looked at three people's financial transaction records and saw where monies had been paid in by a relative or a representative that a receipt had been issued. We looked at the personal allowance records for three people. The amounts invoiced to each person showed the correct balance remained. A statement could be generated for each person with a personal allowance. The administrator told us that people at the service could choose to manage their own monies and may keep money in their room. We spoke with the regional operations manager who assured us that if a person chose to keep monies in their room that a risk assessment would be completed to ensure measures were in place to protect the person from financial abuse.

All the relatives and people spoken with did not express any concerns about the cleanliness of the service. There was a range of cleaning schedules for different areas within the service. For example, the kitchen area, daily cleaning and periodic cleaning schedule. The manager told us that whilst completing a daily walk round they checked the cleanliness of the home. We saw the communal bathroom and toilets were clean and tidy. However, we noticed that one of the communal areas on the first floor had an unpleasant aroma on both days of the inspection. We spoke with the regional operations manager who told us they would investigate the cause and have it addressed.

Requires Improvement

Is the service safe?

On the first day of the inspection we noticed that one of the cleaning trolleys was left unattended in a corridor. We saw people passing by the trolley. The manager covering at the service also identified the issue and spoke with the staff member immediately about the importance of maintaining a safe environment for people.

There was a system in place for staff to record any areas in the service that needed attention and a maintenance worker was employed by the service. We saw evidence that checks were undertaken of the premises. For example, fire systems checks, emergency lighting checks, call system checks and window re-stricter checks. We also saw evidence that checks had been made on equipment used by people living at the service. For example, bath chair, parker bath and hoist checks.

Requires Improvement

Is the service effective?

Our findings

People spoken with told us they were satisfied with the quality of care they had received. Their comments included: “I am being looked after well, no matter what I ask for, they [staff] try to get it”, “I am quite happy, I can’t fault them [staff]”, “the staff are fine, we are treated very well” and “very good”. There was some evidence of personalisation in people’s rooms. For example, people had pictures of their personal interests or photographs which reflected their life history. In one person’s care plan we found the “this is me” document had not been completed. This is a document that can be used to record people’s interests, preferences, life history, likes and dislikes. This could lead to an increased focus on the person’s condition rather than the person behind the diagnosis and potentially develop into caring for "what', rather than ‘who’. We spoke with the person and they told us about their experiences during the second world war and showed us photographs.

Relatives spoken with told us they were satisfied with the quality of care their family member had been provided with and were fully involved in this. One relative commented: “I have no concerns at all, [family member] is well looked after”. However, one relative told us they were not always confident that staff would follow up concerns they had raised because staff did not address their concerns straight away. The response from staff was they would sort it out later or the next day.

Most people spoken with were satisfied with the quality of the food provided at the service. Their comments included: “I like to have porridge every morning”, “that was a lovely bit of fried toast and tomatoes”, “food is really good and you can ask for seconds” and “I like the stewed meat and vegetables”. One person thought the food could be improved and suggested the menus were reviewed and the portions of food were increased. They also suggested that staff change the water in their water jug on a daily basis to ensure it was fresh. One person told us the arrangements for meals could be improved. They commented: “I would like my dinner at twelve but I don’t get it until two or when it suits staff”.

We spoke with the cook; they gave us details of the different choices available at meal times. They told us that menu choices were offered to people on the day before. They were aware of the people who had allergies, required a specialised diet and/or soft diet. We saw there was a choice of food available at meal times for people to choose from. The weekly menus were on display at the service and the nutritional values of meals had been calculated on a separate chart. We observed a staff member asking people for their meal preferences during the inspection.

On the first day of the inspection we used a formal method to observe people which is known as the Short Observational Framework for Inspection (SOFI). This involved us observing people who use services for a period of time and recording their experiences at regular intervals. We spent time observing how people were supported in one of the dining rooms at breakfast time. At the start of the observation a kitchen assistant was serving meals and making drinks for people; a care assistant was not present to support people. The kitchen assistant told us they had started serving breakfast at 9am. We observed care assistants coming in and out of the dining room focussing their attention on taking drinks and meals for people in their rooms. Although we observed the kitchen assistant offering drinks to people, they were not aware of which people required prompting or encouragement to eat.

We observed a person being supported by the kitchen assistant to drink using a beaker. The person was not appropriately supported: the person was unable to drink effectively and their drink was spilt on them. Approximately thirty minutes after our observation started, two care assistants entered the dining room and one of them started supporting the person to drink and eat. However, we saw the person was not treated with consideration. For example, we did not observe the care assistant washing their hands or using gloves before handling the person’s food. Whilst holding a sandwich for the person to eat they held a conversation with another member of staff. They also interrupted the person’s support by supporting another person to go the lounge. Later in the day we spoke with a staff member who had been taking meals to people in the rooms whilst we were in the dining room. They told us the level of support people were provided with in the dining room depended on the number of people the night staff had supported to get out of bed. They said that some people were up before the day staff arrived at 8am and would either be sitting in the lounge or in the dining room. We also spoke with a nurse on duty who said staff had been

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a bit "stretched" during the morning so there had not been a care assistant in the dining room to provide support. This showed that people had not been appropriately supported to eat and drink as required in their care plan.

During the inspection we spent time in one of the lounge areas in the afternoon observing daily life in the service. We noted that there were jugs of juice but there were no glasses available. We did not observe staff prompting people to drink to maintain good hydration levels. We visited people in their rooms and noted in three people's rooms that staff had not ensured the person could reach their drink. We reviewed the daily fluid intake records of one person who needed support to drink. We noted on the 15 December 2014 their fluid intake had not been recorded.

We found that people had not being protected from the risks of inadequate nutrition and dehydration. These findings evidenced a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received mixed messages from staff about the support they received from senior staff. Some staff made very positive comments and felt well supported. They told us they would approach the manager if they had any concerns. Some staff felt the support they received could be improved. For example, one staff member told us there was no point in raising issues a lot of the time because they thought nothing would be done about them.

We spoke with the regional operations managers who told us that staff should receive six supervision sessions a year; one of the supervision sessions would include an appraisal. Supervision is the name for the regular, planned and recorded sessions between a staff member and their manager. It is an opportunity for staff to discuss their performance, training, wellbeing and raise any concerns they may have. It is important for staff to have an annual appraisal as it is an opportunity to review the staff member's performance and to identify their work objectives for the next twelve months. We saw evidence that the new manager of the service had prepared a staff supervision schedule for 2015. We also saw evidence that the new manager had started providing staff with supervisions and an appraisal in some cases. However, records showed and staff feedback told us that some staff had not received a regular supervision. For example, one staff member had received an appraisal from the new manager in November 2014 but they had not received any supervisions sessions during 2014. Another staff member's records showed they had received an appraisal in June 2013 and their last supervision was in May 2014.

The manager used a staff training spread sheet to monitor the training completed by staff. We reviewed the service's training spread sheet and looked at staff records. We saw that staff were provided with a range of training relevant to their role. The training covered a range of areas including: moving and handling, fire safety, infection control, safeguarding vulnerable adults, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguardings (DoLS) and health and safety. The spread sheet showed that a few staff had not completed some of their training. For example, one staff member had started working at the service in June 2014. The spread sheet and their training records showed that they had not completed training in the following areas: food hygiene, moving and handling and health and safety. Another staff member had received safeguarding vulnerable adults training at their last employment but they had not received any training since they started working at the service. We spoke with the manager who told us they had identified that this was an issue and they had started highlighting individual staff member's training whilst providing a supervision and/or an appraisal.

We found the provider had not ensured that staff were appropriately trained and supported to enable them to deliver care to people safely and to an appropriate standard. These findings evidenced a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The manager told us they had recently completed training in DoLS with the local authority as part of their induction. However, the service's training spreads heet showed that only nine staff had completed training in MCA and DoLS. The manager informed us they were liaising with the local authority regarding any requirements regarding DoLS applications. During the inspection we did not observe any evidence of unlawful restriction. For example, people being restricted from leaving the premises.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision-making

Requires Improvement

Is the service effective?

within a legal framework. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and report on what we find. The safeguards are part of the MCA and aim to ensure that people are looked after in a way which does not inappropriately restrict their freedom.

Equipment was available in different areas of the service for staff to access easily to support people who could not mobilise independently. Staff spoken with suggested that an additional hoist and stand aid would be helpful to ensure people's needs were met in a more timely manner.

Although we found evidence of involvement from other professionals such as doctors, opticians, district nurses, tissue viability nurses and speech and language practitioners in people's records. We noted the recording and communication of the visits from the GP could be improved to ensure the advice given was followed.

Requires Improvement

Is the service caring?

Our findings

Most people spoken with made positive comments about the staff and told us they were treated with dignity and respect. Their comments included: "they [staff] are pretty good on the whole", "can't fault the staff, it takes dedication to do this job" and "treated with dignity and respect and humour". Two people spoken with felt that staff did not care about them when they asked for support to move and staff were busy doing other tasks. One person commented: "we are just left; they don't care".

We saw people could choose whether to spend time in their rooms or go to the communal areas. For example, three people on the first floor unit told us they liked to sit by the window and look out at passers-by. One person told us they liked to stay in their room and watch television.

Relatives spoken with also made positive comments about the staff. Their comments included: "the staff are very friendly" and "the staff are quite nice, I have no problems with the staff".

During the inspection we spent time observing how people and staff interacted in different areas within the service. We saw that some staff had positive interactions with people and adapted their communication style to meet the needs of the person they were supporting. For example, crouching down so they were on the same level as people who were seated. However, our observations during the inspection told us that staff interaction with people was mainly centred around tasks. During an observation in one of the lounge areas we observed one person was continually asking what was happening but we did not see any staff coming to reassure them. We observed staff carrying out tasks and talking amongst themselves. When staff passed by the lounge they did not stop and interact with people. We observed one person call out to a nurse for support when they saw them; the nurse's response was to call for a care assistant to respond to the call for assistance.

We observed that a few people's dignity was not maintained. For example, we observed staff passing by a person's room; the person's bedroom door was open. The person was lying in bed, uncovered and was visible to any person passing by. We saw that staff had not made sure the person's dignity was maintained. We spoke with the manager who was covering on the first day of inspection. They had also noticed the person's dignity had not been maintained and had been into the person's room to appropriately cover them. Whilst speaking with one person in their room they told us they needed support with their personal care. A care assistant attended and started to lift up the person's clothing, whilst we were still in the room. We noticed the care assistant had not closed the person's bedroom door. We spoke with the care assistant regarding closing the door. They requested we use the ensuite door to block people's view.

During the inspection we noticed that some staff had become accustomed to using the ensuite door in people's rooms to block people's views whilst providing personal care to people. However, we found any passer-by could over hear the interaction between staff and the person. We noticed two staff did not knock on people's bedroom doors before entering. For example, whilst speaking to a person in the room a care assistant walked into their room whilst holding a conversation with another member of staff. We spoke with the regional operations manager and manager who assured us they we speak with staff.

We also noted that staff had not treated a some people with consideration with regards their comfort. We noticed in two people's room that there were no pillow slips on their pillows; one person had a pillow with a plastic coating on it and the other person had a pillow with a small blood stain on it. We rechecked the people's rooms on the second day of the inspection and found no changes. We spoke with the manager who arranged for the bedding to be changed and a pillow slip placed on people's pillows.

In the reception area of the service there was a range of information available for people and/or their representatives including the following: dignity code, resident's charter, a leaflet about adult abuse and details of advocacy services. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

The manager told us there was one dignity champion at the service. A dignity champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. They believe that care services must be compassionate, person centred, as well as efficient, and are willing to try to do something to achieve this.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the provider had not ensured that all the people living at the service had safe and appropriate care and support to meet their needs. The provider submitted an action plan following our inspection which detailed the actions they intended to take in order to

achieve compliance. At this inspection we found the provider had failed to achieve compliance and were in continued breach of regulation 9.

One of the concerns raised at the last inspection was that staff had not ensured people had a call bell in reach to call for assistance from staff. During this inspection we noted that four people we visited in their rooms still did not have a call bell in reach to call for assistance. For example, one person we spoke with was sat in their chair in their bedroom. We noticed their call bell was lying on their bed. The person told us that they weren't usually given the call bell whilst they were sat in their chair. The person was unable to mobilise independently.

One person spoken with told us staff did not always ensure they could reach their bell when they were lying in bed. They commented: "they [staff] have put the sheets on and forgotten to give me my call buzzer". This showed the provider had not taken effective action to ensure that all the people living at the service could access assistance from staff when they needed support.

People spoken with told us staff had responded when they used their call bell's to call for assistance and the length of time they waited depended on staff availability. Their comments included: "when I ring they come at a reasonable time", "they [staff] are pretty quick to answer the call buzzer", "off and on you have to wait a bit longer for them [staff] to come", "it can be a very long time before staff come", "it varies, if they are changing shift it is a bit longer than normal but pretty good" and "it depends if they [staff] are helping someone else on how long it takes them [staff] to come".

On the first day of the inspection a patient service transport vehicle arrived to provide transport for a person to attend a hospital appointment. The person did not attend the appointment because the staff on duty were unaware the person was attending an appointment and the person was not ready in time. We spoke with a nurse who told us they were not aware the person was attending an appointment because it had not been written in the diary. The nurse subsequently contacted the hospital and made another appointment for the person. This showed the person had not been appropriately supported to access treatment to meet their individual needs.

At our last inspection we found concerns regarding the care being provided to a person who needed dressings changed regularly or when they became soiled. During the inspection we spoke with a GP visiting the service. They told us they had asked a nurse to remove one person's dressings as they had become very soiled which put the person at risk of developing an infection.

We reviewed six people's care records. People's care plans contained a range of information including the following: personal hygiene, mobility, communication, eating and drinking. We found the provider had not taken effective action to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe. For example, one person's risk assessment had not been reviewed after they had sustained a recent fall. We also found the falls risk assessment in place did not reflect the person's currently mobility. In another person's care plan, records showed that there was a lack of continuity of care being provided. For example, between the 24 October 2014 and 14 November 2014 there was no evidence to show that a wound had been evaluated. We also saw there was no entries in the person's care plan evaluation to confirm the person's dressing had been changed on the 28 November 2014, or the condition of the wound, although there was an entry on their on going wound assessment.

We reviewed two people's records who had behaviour that could challenge others due to conditions attributed to living with dementia. A challenging behaviour chart was being used to monitor their behaviour; to see what could have triggered the behaviour and to look for patterns in people's behaviour. Although a chart was in place we found that they were not being used effectively. Staff were not picking up subtle signs to enable them to identify triggers. For example, environmental or physical factors. This told us there was a risk that some people's behaviour was not managed consistently and the risks to their health, welfare and safety were not managed.

These findings evidenced a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

The complaints process was on display at the service. We noted the complaints process contained in the "where people matter" documentation needed amending to reflect the change of manager. The Dalewood View service user guide complaints section also needed updating with details of the new manager. The contact number and address of the regional operations manager had not been included in the guide. We spoke with the manager and the regional operations manager and they assured us that these amendments would be made.

We reviewed the service's complaints log. We found the service had responded to people's and/or their representative's concerns, investigated them and taken action to address their concerns. People spoken with told us they did not have any concerns or complaints and if they did they would speak with staff or a family member. Relatives spoken with told us they were aware of how to complain and who to speak with. One relative told us that they had recently made a verbal complaint to staff and their concern had been addressed. However, when we spoke with the manager and provided them with details of the complaint they were not aware of it. They told us they would speak with staff with regards the importance of recording and reporting verbal complaints to senior staff.

There was an activities room on the lower ground floor area within the service. There was an activities board on each floor of service which provided details of the daily activities. There were details of the monthly services held by the local churches at the service on display. The service had held a resident's Christmas party on the 11 December 2014 and a Christmas fair on the 13 December 2014. Some people spoken with told us they had enjoyed a recent visit by the local brownies. The manager told us that some people were going to see a pantomime at the beginning of January 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the provider had not ensured there was an effective system in place to regularly assess and monitor of the quality of the service provided. The provider submitted an action plan following our inspection which detailed the actions they intended to take in order to achieve compliance. At this inspection we found the provider had failed to achieve compliance and were in continued breach of regulation 10.

The registered manager for the service was no longer in post and not managing the regulated activities at this location at the time of the inspection.

The new manager told us they had started working for the provider in August 2014 and completed a six week induction at another service. The manager told us they regularly attended staff handovers and completed a daily walk around and recorded their findings on a form. We reviewed two of the completed forms and saw that the manager checked a range of areas which included the following: the cleanliness of the service, availability of equipment, staff hand washing practices, a sample of care records, a sample of medications, some people's appearance and arrangements for meals. The manager also provided us with copies of two of the head of department flash meetings completed in December 2014. The key areas covered included: housekeeping, care, maintenance/garden, administration and activities.

Although a dependency assessment had been completed regularly by the new manager to ensure there were sufficient numbers of staff with the right skills and knowledge working on each unit during the day and night, we found the arrangements in place to ensure people were supported with eating appropriately were not in place. This showed that the provider had not protected service users, who may be at risk, against the risks of inappropriate or unsafe care by having effective operational systems in place to manage care provision within the service.

The service had a process in place for staff to record accidents and untoward occurrences. The manager had completed a falls summary report in 2014. This report provided details of the time of the fall, location of the fall, cause and whether it had been witnessed. The manager told us the report had been discussed at the provider's health and safety meeting but this had not resulted in an action plan being completed. Care staff spoken with were able to describe how incidents were reported and recorded. However, we noted during the inspection that an incident form had not been completed for a falls incident that had occurred on the 12 December 2014 by staff. It is important that incidents are recorded and reported promptly so that an accurate record is obtained and ensure that appropriate action is taken.

Although we saw evidence that a medication audit had been completed in October and November 2014, our findings during the inspection showed that the system for monitoring the management of medicines were not robust. It is essential to have robust monitoring in place in order to identify concerns, to make improvements and changes needed to ensure medicines are managed safely.

We found that some staff had not received training in areas relevant to their roles. This showed that there were not suitable arrangements in place to ensure staff were properly trained. This meant the system for auditing and monitoring staff training was ineffective in practice. We also found that some staff had not received regular supervisions or an appraisal. This showed the service did not ensure staff received appropriate training, professional development, supervision and appraisal. This meant the system for auditing and monitoring staff supervision was ineffective in practice.

We reviewed the results of the service user survey dated 30 September 2014. The survey covered a range of topics including the following: staff, quality of the food, feeling safe, the complaints process and activities. Although people's experiences had been sought and listened to an action plan had not been completed so improvements could be made. For example, seventeen people had said they would like to try different meals. The manager told us a residents meeting had been scheduled for the 3 October 2014 but as people had failed to attend a questionnaire had been completed with fifteen people living at the service. We reviewed a copy of the results of the questionnaires. The questionnaire results included details of the action to be taken. For example, to ensure that other snacks are available not just chocolate or crisps.

The results of the resident's relative survey completed in September 2014 were on display in the reception area. The survey covered a range of topics including the following: cleanliness of the home, staff, activities programme, response to telephone calls, communication and whether

Inadequate

Is the service well-led?

their relative was wearing their glasses, hearing aids/ dentures when they visited. However, we found the manager had not used their views to complete an action plan.

We reviewed the minutes of the relatives meeting held on the 3 October 2014. The minutes also included an action plan which had been signed off when the action had been completed. For example, the overhanging trees had been cut down to increase the light in some people's rooms. We noted that as part of the action agreed was to ensure staff had their name badges on at all times. During the inspection we noticed that some staff were not wearing badges. This showed the action agreed at the meeting had not been actioned effectively. People living with memory impairment may not always remember a staff member's name. Wearing name badges enables visitors to the service to clearly identify staff they have spoken with or the staff on duty.

We saw that checks had been completed at the service by the provider since the last inspection. An interim visit by the provider's chairman had been undertaken in September 2014 and an action plan had been given to the service to complete. We also saw evidence that the regional operations manager had regularly visited the service and completed an audit. Their audit covered a range of areas including the following: sample of care plans, environment and maintenance. A discussion with people, relatives and staff had been undertaken as part to the audit. We found these checks had not effectively ensured that all the people living at the service had safe and appropriated care and support to meet their needs.

This meant the system to regularly assess and monitor of the quality of the service provided was ineffective in practice. These findings evidenced a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. There was a process in place to ensure incidents were monitored to identify any trends and prevent recurrences where possible.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: People were not being protected from the risks of inadequate nutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The provider had not ensured that staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe.

The enforcement action we took:
We have served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.

The enforcement action we took:
We have served a warning notice.