Care Quality Commission

Tamaris Healthcare (England) Limited

Hallcroft 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of the service on 18, 19 and 20 February 2015.

Hallcroft Care Home provides accommodation for people who require nursing or personal care. On the day of our inspection 27 people were using the service. There was a manager in place, but they had not applied to become registered with the Care Quality Commission.

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

During our inspection on 12 August 2014 we identified four breaches of the Regulations of the Health and Social Care Act 2008. These were in relation to people's care and welfare, assessing and monitoring of the quality of service provision, consent to care and treatment and maintaining

Summary of findings

people's records. During this inspection we found improvements had not been made and we identified a further breach of the Regulations. This was in relation to a lack of support in place for staff at the home.

You can see what action we told the provider to take at the back of the full version of the report.

People were provided with information in the home which explained who they could contact if they felt they or others had been the victim of abuse.

People's needs were not always appropriately assessed and recorded within their care plan. The information recorded did not always reflect people's current level of need, which placed their safety at risk. People's safety was also placed at risk because personal emergency evacuation plans (PEEP), used to advise staff how to evacuate people in an emergency, were not in place.

People were not supported by an appropriate number of staff in order to keep them safe and to meet their individual needs. People had to wait a long period of time for staff to respond when they pressed their nursing call bell for help.

People's records relating to their medicines were not always appropriately completed. Where people lacked the mental capacity to consent to care and treatment, staff had not always followed the principles of the Mental Capacity Act 2005 (MCA).

We identified a number of people whose liberty was unlawfully restricted as they were unable to leave the premises if they wanted to, as the exit was controlled by a key pad system.

People raised concerns with us regarding the effectiveness of the agency staff who worked at the home. Not all agency staff received an induction prior to commencing their role at the home. The staff we spoke with told us they did not feel supported by the management team. Staff performance and ability to carry out their role was not regularly assessed. The home had three nurses who were new to the home and they had limited knowledge of people's needs.

People were able to see external health professionals; however referrals made by the manager did not always occur in a timely manner.

People said they did not always get the food they had requested, although others spoke positively about the food. People's weights were taken regularly although food and fluid intake charts, used to monitor how much food and drink people consumed were not completed appropriately.

There were some positive interactions between people and some of the staff although we saw little engagement with people if care and support was not being offered. People were not always treated with dignity and respect and staff did not respond quickly enough to people who were showing signs of distress. Some people were visibly upset by the actions or in some cases, inaction of the staff.

Information was available for people if they wished to be supported by an Independent Mental Capacity Act Advocate (IMCA).

People were not supported to pursue interests that were important to them. People did not always receive care and support that had been agreed with them at the time their care plan was formed. People did not receive showers and baths when they wanted them. People were not protected from the risks of social isolation and many people spent long periods of the day alone in their bedroom. People did not feel that complaints they made were responded to appropriately.

People were not supported by a staff team that was well led by their manager. Some staff felt they were blamed by the managers for the failures at the home. There was no structured process in place which identified risks to the service and how to improve the service that people received. This home did not have a set of values, goals and aims that were explained to staff and people who used the service. Feedback received from people and their relatives had not been used to improve the home.

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?
The service was not safe.

There were not enough staff to meet people's needs. Nursing call bells went unanswered for long periods of time.

There were no personal evacuation plans in place to evacuate people safely in an emergency.

Records relating to people's medicines were not appropriately maintained.

Inadequate

Is the service effective?
The service was not effective.

People raised concerns as to the effectiveness of some of the staff who supported them.

Staff did not receive appropriate support from the manager in order to carry out their role effectively.

Some people were unlawfully restricted and were unable to leave the premises. Assessments of people's capacity to make decisions were not always conducted appropriately.

Inadequate

Is the service caring?
The service was not caring.

People were not always treated with respect and dignity and their independence was not always maintained.

Staff did not respond to people's distress or discomfort in a timely manner.

People had information available to them if they required independent advice when making decisions about their care.

Requires Improvement

Is the service responsive?
The service was not responsive.

People's care plan records were not always appropriately completed and the information within them did not contain information that enabled to staff to respond to people's current level of need.

People were not protected from social isolation and some spent long periods of the day alone in their bedrooms.

People were unable to pursue the hobbies and interest that were important to them.

Requires Improvement

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Improvements had not been made to the service following our previous inspection and further concerns were identified.

The working relationship between staff and the management was poor. Staff felt they were blamed for the failings at this home.

Risks to the service had not been identified by the manager and there was no structured process in place to improve the quality of the service people received.

Hallcroft 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 on 18, 19 and 20 February 2015 and was unannounced.

The inspection team consisted of four inspectors and a specialist advisor with a background in nursing.

To help us plan our inspection we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted Commissioners (who fund the care for some people) of the service and other healthcare professionals and asked them for their views.

We spoke with 10 people who used the service, five relatives, four healthcare professionals, eight members of the care staff, a kitchen assistant, the manager, regional manager and a managing director. We also spoke with a support manager who was a registered manager at another service within the provider's group of services. They were supporting the manager of the home for two days a week due to them being new to their role.

We looked at all or parts of the care records of ten people along with other records relevant to the running of the service.

Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

During our previous inspection on 12 August 2014 we identified a breach of Regulations 9, 10 and 20 of the Health and Social Care Act 2008. We concluded that people's care and welfare needs were not always appropriately met, risks to people's care and the quality of the service they received had not been assessed or regularly reviewed by the manager, and records relevant to the running of the service had not been completed appropriately. During this inspection we found further concerns.

People told us they were concerned that their safety or the safety of others may be at risk at this home. A person who used the service told us, "I often have to use the walking frame to get to the toilet as they [staff] don't come and I worry that I will become incontinent." Their relative said, "It is not safe for them to walk on their own." A person who used the service told us, "They [staff] say they have a lot of people to deal with and I have to wait my turn. It is upsetting." Another relative said, "[Family member] stays in bed all day and is unable to get up. Staff rarely answer the call bell. You have to go and find someone which hard most of the time."

Each staff member we spoke with told us they did not think people were safe. One staff member said, "Honestly, if I had a relative in here, I wouldn't sleep at night worrying for their safety." Another staff member said, "People are not safe and the staffing levels do not let us promote safety."

People's safety was placed at risk because personal emergency evacuation plans (PEEP), used to advise staff how to evacuate people in an emergency were not in place. We spoke with a member of staff about this and they said, "The lack of evacuation documentation is a major problem."

People's needs were not always appropriately assessed and recorded within their care plan. The information recorded did not always reflect people's current level of need, which placed their safety at risk. We observed a person who was slumped in their chair in the lounge with their head in their lap, and they were unable to move themselves into a more comfortable position. In a 30 minute period no member of staff approached this person. We raised this with a member of staff. Two members of staff attempted to move the person with the assistance of a walking aid. We saw the person was unable to move their legs independently, however staff had not realised this which caused the person to become unstable, placing their safety at risk. We looked at the person's care plan; it stated their mobility needs had been assessed as 'low risk'. This did not reflect the person's current level of mobility.

We looked at the mobility needs care plan of another person who had been assessed as 'high risk'. The care plan stated a hoist and two members of staff were required to assist this person to mobilise safely. The person told us staff had dragged their chair with them sat in it, over to their bed instead of using a hoist. The chair broke and placed this person's safety at risk. We reported this to the manager who was unaware of the incident and told us they would investigate.

People's safety was placed at risk as there was not a consistent process in place that ensured people who were unable to safely reposition themselves were regularly repositioned by staff. We looked at a person's care plan which had assessed them as 'low risk' of forming a pressure ulcer. We discussed this with the support manager and they said, "They are definitely high risk." We spoke with a healthcare professional about the tissue viability needs of another person who used the service. They told us, "I am concerned if continuity of care cannot be maintained for this person, they will be put significantly at risk."

The safety of a person who was dependent on insulin to manage their diabetes was placed at risk. Their care plan did not specify the blood sugar levels for staff to monitor in order to keep the person safe and healthy. The person's care plan did not contain guidance for staff to follow if the person had one a seizure due to their blood sugar level being too high, placing this person's welfare and safety at risk.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by enough staff in order to keep them safe. One person said, "I really just want someone to help me." Throughout the inspection we had to respond to some call bells as there were not enough staff to attend to people when they needed them. We responded to one call bell that had been ringing for 13 minutes. The relative told

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Is the service safe?

us that as a result of no staff attending they had to assist their family member to use the toilet on their own which was difficult to do. The lack of a staff response placed the safety of the person and their relative at risk.

We identified other examples were people were left waiting for a long period of time for staff to assist them. For example, we had to ask staff to help a person who had been left sitting in their wheelchair in the middle of lounge. The person told us they had been waiting for an hour and twenty minutes. They had become very upset and began to cry. They said, "I just want to go back to my room." We asked a staff member why there were so few staff in the lounge to support people. They told two staff members had gone on their break together and there was no structured plan in place that ensured there were sufficient staff available at all times to support people in the lounge. The lack of staff available to support people placed people's welfare and safety at risk.

People who were being nursed in their beds were also left waiting for a long period of time for staff to respond when they pressed their call bell. We responded to another call bell that had been ringing for 9 minutes. The person told us, "It can take them [staff] much longer [to respond]. A couple of days ago I pressed my buzzer at 6.20pm, no-one came until 7.30pm. I got really upset when no-one came to see me for that length of time." The length of time taken for staff to attend to people who required assistance placed people's safety at risk. We spoke with the home manager about the number of call bells that were unanswered. They told us they were one member of staff down and had been unable to replace them. They had not assessed the risk a lower number of staff could have on people and had not put measures in place to address this risk. This increased the risk to people's welfare and safety.

We spoke with a member of staff about the nursing call bells. They said, "The buzzers never stop, it's a constant buzzer due to [people's] high dependency and people needing reassurance; but they often don't get it, as there are not enough staff to meet the needs of people's safely." Another member of staff said, "There are days when we are short staffed and it does place people's safety at risk. We just can't get everything done." A health care professional told us; "There are never any staff around when you arrive or want to see a patient."

The manager had not assessed and managed the risk to people by ensuring there were a suitable number of staff to meet their needs. This placed people's health, welfare and safety and risk.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines when they needed them. People's medicines were stored and secured safely. Regular checks of the temperature of the fridge and the room they were stored in were carried out to ensure they were kept at a safe temperature. Medicines stored at an inappropriate temperature could have a detrimental effect on the quality of the medicines.

People were not protected against the risks associated with records relating to medicines. People's care plans contained conflicting information in relation to people's ability to manage their own medicines, which meant people may not receive the appropriate support. We saw the controlled drugs register showed morphine had been administered to a person, but had not been recorded on the person's medicine administration records (MAR). This meant other members of staff would not have the most up to date information available to them and they could attempt to administer this medicine again, placing this person's safety at risk.

On some of the MAR records we looked at we found staff signatures were missing and gaps where people should have received their medicine. The records are used to record when a person has taken or has refused to take their medicines. We also found some gaps on the topical medicine administration charts. (TMAR). A topical medication is a medication that is applied to body surfaces such as the skin to treat ailments with a range of creams, foams, gels, lotions, and ointments. The manager could not explain the reason for the gaps, so we could not be certain all people had received all of their medicines. The lack of robust records which accurately record what medicines people have had and when could place people's health, safety and welfare at risk.

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Is the service safe?

These were breaches of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of the potential signs of abuse and could explained who they would report concerns to both internally and externally to agencies such as the CQC. Staff had received training to protect vulnerable people from abuse. People were provided with information in the home which explained who they could contact if they felt they or others had been the victim of abuse.

Inadequate

Is the service effective?

Our findings

During our previous inspection on 12 August 2014 we identified a breach of Regulation 18 of the Health and Social Care Act 2008. We identified concerns that the principles of the Mental Capacity Act 2005 were not being appropriately applied when decisions were made for people who could not give their own consent. During this inspection we found improvements had not been made and we identified further concerns about consent of care.

Where people lacked the mental capacity to consent to care and treatment, staff had not always followed the principles of the Mental Capacity Act 2005 (MCA). The MCA is legislation used to protect people who might not be able to make informed decisions on their own about the care and support they received. We observed a person who was sat in their wheelchair; they had a lap belt used to secure them. We looked at the person's care plan which stated the person was unable to communicate verbally and complex decisions should be made and documented with all relevant professionals and next of kin. We saw no Mental Capacity Act (MCA) assessment regarding the specific decision about the use of a lap belt. Staff were unable to find these documents. This meant this person may have been restricted without the appropriate consent obtained for this decision.

We saw a person had bed rails attached to their bed. Bed rails can be used to ensure people are who are at risk of falling out of their bed are protected. However, they can restrict a person's freedom to leave their bed if they wished to. We saw there was no MCA assessment or documents in place regarding the specific decision of the use of the bed rails. We asked the manager if there was documentation in place to support this decision. They confirmed there was not. This meant the decision to restrict this person's ability to move out of their bed was in place without the appropriate consent obtained for this decision.

People's care plans did not always provide enough information about what decisions people could make. For example, we looked at a person's care plan which stated they were able to make 'non-complex choices and decisions', but made no reference as to what these decisions were. This meant the person may not receive effective support from staff when making decisions regarding their care and support.

The manager could explain the process they followed when applying for authorisation for Deprivation of Liberty Safeguards (DoLS) to be implemented to protect people within the home. Our observations throughout the inspection identified a number of people whose liberty may have been unlawfully restricted as they were unable to leave the premises if they wanted to. The front door was locked and people required a code to leave. Appropriate assessments had not been completed and DoLS had not formally been requested for these people.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People raised concerns with us regarding the effectiveness of the agency staff who worked at the home. One person said, "Some of the agency staff are lovely, but some I wouldn't employ in any job. How on earth did they get their job? It's crazy."

We spoke with the manager and asked them whether agency staff received an induction before commencing their role. They told us they did. We checked the records which showed some of the agency staff had received this induction, however there were no records in place for two of the agency staff working at the home at the time of the inspection. The manager could not confirm whether these two members of staff had received this induction. We spoke with one of the agency staff. They told us, "I am looking after 15 or 16 people. I do not know any of their names. I have had nothing written down." A permanent member of staff said, "They [agency staff] turn up and I have no idea how they would have an idea of people's needs." This meant people's health and welfare was potentially placed at risk due to the lack of appropriate support for agency staff in order to carry out their roles effectively.

People were not protected by staff who had their work regularly reviewed. Records showed staff had not received an assessment of their work since June 2014 and had not received an annual appraisal of their work. The home's policy stated that staff must receive 'a minimum of one supervision every two months'. The manager confirmed that supervisions and appraisals had not been completed. The staff we spoke with told us they did not feel supported by the management team. A member of staff said, "I had a one to one last year, in June I think, but nothing since then.

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Is the service effective?

I don't really know if I would be supported [by the manager] as I don't know her yet." Another said, "Three years ago everything was good, we had a regular manager but now there is no stability. We don't have anybody we can go to [for advice]. Not even a regular nurse."

The lack of regular assessment of staff's work could result in staff providing care and support that was not effective, placing people's welfare at risk.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by nurses who had sufficient knowledge of their needs in order to provide them with effective care and treatment. All of the nurses had limited experience of working at this home. We asked one of the nurses whether they had enough information in order to carry out their role effectively. They said, "There is not enough information within the notes (care plans) for me to do what I need to do." The nurse's lack of knowledge of people's needs could place the health and welfare of people at the home at risk.

On the third day of the inspection we arrived to see an ambulance was on the premises and paramedics were entering the building and responding to an emergency call. The nurse was unable to provide the information requested by the paramedic from the information within the care plan. The nurse said, "The information is very difficult to find. I have no idea how the system works." The lack of information for the paramedics placed the health and welfare of this person at risk.

People were able to see external professionals when they needed. People told us they were able to see their GP, chiropodist and dentist when required. However we saw referrals to relevant health services were not always made by the manager when people's needs changed. A person told us, "When I came here I could walk fine. But through the lack of use of legs I can't now. I have never had anyone help me with my legs." We raised this with the manager and asked them whether this person had been referred to a physiotherapist. They said they had, but only recently. The delay in referring this person may have had a negative impact on their ability to improve their mobility.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us mixed feedback on their views of the quality of the food that was served. One person described the food as "fantastic", another said, "The food is good and bad." A relative we spoke with told us, "[Family member] often orders things off the menu that never appear." Another relative told us, "Staff do not wake [family member] to eat their meals, so they just go cold and then [family member] leaves them."

We observed the lunchtime meal being served in the dining room. There were pictures of food on the menu board on the wall to assist people in making a choice. The people we observed received enough to eat and drink. The atmosphere in the dining room was calm and relaxed. People were not rushed and there were enough staff present to support the people in the room. Staff asked people if they had had enough to eat. We spoke with a kitchen assistant. They could identify people's likes and dislikes and had information about people's dietary needs on a board in the kitchen. For example we saw details were recorded for a person who was at risk of choking.

People at risk of malnutrition or dehydration had their weight monitored and their food and fluid intake recorded. The records were used to record the amount of food and drink a person had consumed in order for staff to identify any trends that could pose a risk to the person's health. We found gaps on the records we looked at and in some cases no entries had been recorded stating whether a person had had a drink or some food or whether they had refused. Additionally the total amount people had consumed had not been recorded which meant staff would be unable to monitor whether people were receiving their recommended amount, in order for their health to be maintained. The lack of accurate record keeping could mean people did not receive effective care and support from staff.

This was a continued breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Some people told us they thought they were well looked after by the staff but other raised concerns about the agency staff. One person said, "I am well looked after here. The staff are all nice." However others expressed concern about the way that some of the staff supported them. One person said, "All the staff seem to be upstairs, I get forgotten about down here."

We carried out observations throughout the inspection to see how staff interacted with people. We saw some good practice from the staff who were permanently employed by the service. The staff were kind and treated people with dignity and respect. We observed the employed staff assisting people to transfer from their wheelchairs into armchairs using hoists. We saw a care assistant explain to them what they were doing as they were being supported. Some of the people the staff were supporting were not able to verbally communicate, however we saw the staff member talked to them in a way that made them feel they had their full attention and that they mattered. Whilst the employed staff did interact well with people, this was predominantly task-led. We did not see staff sitting and talking with people unless they were providing care or support.

Some of the agency staff did not talk with people when supporting them and did not treat people with the respect they deserved. We saw one agency member of staff was providing one to one support for a person. They did not talk to them and did not interact with them in a way that showed they had an interest in anything the person had to say. We observed this same agency staff member ask people if they would like a cup tea in a way that was not respectful. We saw this member of staff assist someone with eating their meal and also taking a person to their room with the use of their wheelchair. We did not see this staff member talk with people whilst doing so. These were poor interactions which showed this staff member was not supporting people in a respectful and meaningful way.

People's distress and discomfort were not attended to by staff in a timely manner. We saw a person was sitting in their wheelchair in the lounge. We saw the footplates; used to support their feet whilst sat in the wheelchair were at an angle. They had one foot on the ground and another just off the ground. This person was unable to verbally communicate. The position of this person's legs may have caused the person discomfort or pain in their legs. We did not see any member of staff identify this nor take action. We spoke with another person who was sitting in their wheelchair. They told us they would prefer to be sitting in a softer chair. No member of staff had asked this person if they would like support to move out of their wheelchair to a more comfortable chair, meaning staff had not ensured that they regularly asked people how they wanted to supported.

People did not always feel involved with making decisions about their own care and told us they did not always feel that staff listened to them. We spoke with a person who was being cared for in bed. They told us they were very protective of their personal space and wanted to do as much for themselves as they could. They told us they had requested staff to support them in a specific way but some of the staff had not listened to them. They also told us that some staff moved the things close to their bed which made it difficult for them to support themselves whilst in their room. The person told us, "If you speak to the staff about it they don't really want to hear."

A person told us at times they were unable to make their own decisions which had an impact on their independence. They told us they had asked staff to assist them to get out of bed, but staff often tried to talk them out of it. They told us recently they had been sat in the lounge which they enjoyed but when they asked to go back to their room, "The staff kept making excuses and delaying it, I became very uncomfortable." People were not supported by all of the staff to make their own independent decisions and this has had a detrimental effect on people's health and welfare.

There is a dignity champion at the home. A dignity champion is someone ensures that people are treated with dignity by the staff and others at the home. Information was made available in the home for people to enable them to be confident that they were received care and support that maintained their dignity. However, people's dignity was not always maintained. A person told us they wanted to use their en-suite when they needed the toilet, but staff kept putting them on the commode. The person told us they did not like using the commode but, "I don't like to complain." This had a direct impact on this person's dignity and staff did not respond to this person's wishes. Another person told us they felt wet most of the time and the staff rarely checked them or changed their continence pad in

Requires Improvement

Is the service caring?

the night. This person also told us the only way they could get attention from the staff is if they shouted for help, as the staff don't respond to their buzzer. We heard this person shout for help on two occasions during the inspection. The actions of the staff had a direct impact on this person's dignity.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulations 10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's information was not always treated confidentially. Care plans were stored in a locked room to ensure people could not gain unauthorised accessed to people's records. However, we observed a nurse leave people's medicine administration records on top of the portable medicine cabinet in the corridor when they went into a person's room to give them their medicines. This meant people could have gained access to people's confidential records.

The manager had ensured that information was available for people if they wished to be supported by an Independent Mental Capacity Act Advocate (IMCA) to make major decisions. IMCAs support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

People's relatives and friends were able to visit them without being unnecessarily restricted. The manager told us they wanted people to be able to see the people that were important to them. The people we spoke with did not raise any concerns that they were unable to see their friends or relatives.

Requires Improvement

Is the service responsive?

Our findings

Some people expressed concern that they were unable to do the things that interested them. One person we spoke with said, "I have not been asked about my interests. I have to jog their [staff members'] memory over things I like to do." Another person said, "I have not observed anyone taking part in an activity." Another said, "I used to like cooking. I am not offered the opportunity to do this here. I just sit here." Another person said, "There are no activities."

People's personal preferences and likes and dislikes were recorded in their care plans. Some of the staff knew people well and responded to their wishes. However people were not supported to follow the interests that were important to them. For long periods of the day there were no activities, with people sat for long periods of time either in the lounge or in their rooms. We did see an external person come to the home to do some chair exercises and dances with people, but this was for no longer than an hour. We discussed the lack of activities with the manager. They told us an activities coordinator had now been recruited and their role will be to speak with people and to plan activities that meet their needs. They acknowledged that not enough was currently being done to support people's interests.

Staff did not always provide the care and support for people that had been agreed with them at the time their care plan was formed. For example, we saw the care plan for one person which stated, '[Name] expects a good standard of hygiene to be delivered by two carers. They expect to have a bath/shower at least twice a week.' We looked at this person's 'monthly welfare charts' for February 2015. These charts were used to record how often they had received a bath or shower. We saw there was no entry for this person from 1 to 19 February 2015. We looked at the records for two other people with the same result. We spoke with a person about this. They told us they had refused bed baths because the staff were rough and hurt their neck. They told us they had not had a shower for a month. We spoke with another person and they told us that they only received a bed bath and had not had a shower for weeks.

We also spoke with a member of staff about this. They said, "We don't have time to shower people, trim their nails and shave people. We can't provide the care we used to provide anymore as there aren't enough staff." This meant staff were not responding appropriately to the wishes of people and support was not planned to meet their individual needs.

People were not protected from the risk of social isolation. Some of the people spent long periods, if not all of the day in their room with very little social interaction. A relative of a person who used the service told us, "They [staff] don't do enough for [family member]; they [staff] don't talk to them. They don't see anyone for hours and they rarely leave their room, [family member] is depressed. I often have to put them in their wheelchair and take them to the lounge as they need to be around people more." A person who used the service told us, "I enjoy going downstairs but I only go once a week. Staff sometimes ask if I want to go downstairs, but I feel embarrassed about wearing the continence pads. All the staff tend to stay downstairs, nobody just pops in [to their bedroom]." Staff did not ensure that people who were being cared for in their beds had the opportunity to engage with other people at the home. This could have a detrimental effect on people's mental health as people's needs were not always being responded to.

It was difficult to understand the care and support people needed because there was not a consistent approach to recording the information. We found some risk assessments and care plans had been reviewed and others had not. The records did not always include details of who had been involved with the review and how each person had contributed to the decisions made. Care plans had some elements of person centred planning, but we found people's wishes had not been responded to. We were told by the managing director that they were aware of the issues with the care plans and a new style of care plan was to be implemented which would address these concerns. However, the poor quality of the information recorded within the care plans could place the health and welfare of people at risk.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with information on how they could make a complaint. The process was available in the reception area of the home and was also provided in a

Requires Improvement

Is the service responsive?

guide to the home, provided to people when they first arrived. We also saw a suggestion box in the reception area for people to raise anonymous suggestions about how the home could be improved. However some of the people we spoke with did not feel their concerns were welcomed or acted on appropriately. A person told us, "I have asked to see the manager several times to make a complaint, but they have only come to see me once." Another person handed us a copy of a letter of complaint they intended to hand to the manager and to send to head office of the home. They told us they had done so before and had not received a response. A relative we spoke with said, "You have to talk to the receptionist [to make a complaint] as the manager is never around. Nothing ever changes though, so I take my complaints to the Local Authority." The manager could not provide us with details of how they used the information received from the complaints people had made to improve the quality of the service they received.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Some of the people we spoke with raised concerns with us about the quality of the management at the home. One person said; "I don't know the manager." Another said, I know who the manager is, I can recognise them by their pinny [pinafore]. However I don't know their name." A relative said, "The managers change here, no one has stayed. I don't know if they've got a manager now."

Prior to this inspection we were informed by Nottinghamshire County Council (NCC) commissioners and NHS Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Group (CCG) that they had suspended their contract with the Hallcroft Care Home. This meant they were no longer sending people who required care and treatment to the home until sufficient improvements had been made to the quality of the service provided and they were confident that people were safe.

People did not receive support from, and staff were not supported by, a manager that was registered with CQC. The manager commenced their role in December 2014. At the time of the inspection they had not applied to the CQC to become registered. The previous registered manager left the home on 22 August 2014. This meant at the time of the inspection there had been a period of almost six months where there was no registered manager at the home.

The manager was being supported by a regional manager and a registered manager from another home. However, it was clear when speaking with the regional manager and the manager that they did not have a working relationship that had identified the challenges and risks faced by the home. There was no structured process which identified how they would work together to improve the service that people received. We saw the manager did not have access to all of the computerised systems which restricted them being able to carry out their role.

This home did not have a set of values, goals and aims that were explained to staff and people who used the service. The staff operated independently of the management with no process in place that ensured that the care and support provided by the staff was carried out in line with the agreed values and aims of the service. This meant there was no consistency to the level of care and support people received. Some of the people who were less dependent on the staff for support told us they received a good service. People who were more dependent on the staff told us they did not. One member of staff told us, "We do try our best but there is no respect and dignity for people, staff have got totally demoralised and some have left." Another staff member said, "We have no support, no focus. We are frustrated and tired. Some the management can be quite rude and I have seen them talk to residents quite badly sometimes. There is no stability here at all."

There was not an open and transparent culture within the staffing team. The staff were not well led by the manager. The manager told us they wanted staff to feel part of the team and to be accountable for what they did but there was no process in place for holding people accountable for their work. The manager told us staff meetings took place where staff could raise concerns. However, some of the staff we spoke with felt they were unable to contribute and felt the way these meetings were conducted gave the impression that staff were to blame for the failings within the home. One staff member said, "We get blamed when things go wrong. It's not our fault it is the manager's." The conflict between the management and the staff has resulted in a staff team which has no clear direction of what is expected of them and staff are left feeling unappreciated. This fragmented staffing team has impacted on people who use the service, with staff leaving, a high dependency on agency staff and a management team that has not had a consistent structure for almost six months. This all had a direct impact on the health, safety and welfare of some of the people who used the service.

The people we spoke with were unaware of the customer satisfaction survey for 2014 or whether the results of this survey had led to any improvements within the home. One person said, "I am unaware of any surveys." We were given a copy of the results which stated that 23 surveys had been sent out to people and their relatives. They received 6 responses. No plan had been put in place to address the concerns raised within the questionnaire and to improve the quality of the service people received. The manager could not confirm whether all people had received a copy of the questionnaire or whether support had been offered for people to complete it if they required it. This meant the views of all people may not have been requested and represented.

People were not supported by a management team that had a robust process for regularly reviewing the quality of

Inadequate

Is the service well-led?

the service they received and the risks they faced within the home. We were shown a new system which was due to be put in place which would focus on areas such as; the cleanliness of the home and the quality of people's care planning documentation. However there were currently no processes in place that identified potential risks within the home, which placed the welfare of people at risk.

People's care planning documentation was not appropriately reviewed by the manager or other appropriate person and recommendations made were not always followed up. We looked at a person's care plan which stated that the person was 'unable to weight bear'. This meant the person was unable to put their full weight on their legs without support from staff. On 6 December 2014, the manager had written instructions in the care plan which stated; 'This care plan will need to be reviewed in 4 weeks' time.' No review had taken place since that date.

The lack of a robust audit of the care plans had meant the manager was unable to identify that a review they had recommended had not taken place. This meant the person may not have received care and support that was reflective of their current needs.

When we raised the issues within this report with the manager, they were unaware of many of the concerns. They did not have effective systems in place in order to identify risk and to protect service users and others within the home.

These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person. The registered person did not always act in accordance with the 2005 Act when people were unable to give their consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not established to operate effectively to ensure compliance with the requirements for this Regulation Records were not always accurate, complete and contemporaneous in respect of each service user, including a record of the care and treatment provided to each service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the requirements of this Regulation. Some persons employed by the service provider in the provision of a regulated activity did not- Receive appropriate support, supervision and appraisal that was necessary to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users. The registered person did not comply with parts of this Regulation as they had not always- Assessed the risks to the health and safety of service users of receiving the care or treatment; Done all that was reasonably practicable to mitigate any such risks; Ensured that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not established and operated effectively to ensure compliance with the requirements of this Regulation. The systems or processes did not enable the registered person to— Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.