Ideal Care Homes (Kirklees) Limited

Greenacres

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 inspected Greenacres on 8, 19 and 20 January 2015. The visit was unannounced. Our last inspection took place on 3 June 2014 and, at that time, we found the service was not meeting the regulations relating to respecting and involving people who used the service, care and welfare of people who used the service, staffing and assessing and monitoring the quality of service provision. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to ensure they were meeting the regulations. On this visit we checked and found improvements had not been made in all of the required areas.

Greenacres provides accommodation and personal care for up to 64 older people including people living with dementia. It does not provide nursing care. The accommodation for people is arranged over two floors. There are two units per floor. Each unit has single bedrooms which have en-suite facilities. There are

Summary of findings

communal bathrooms and toilets throughout the home. There are open plan communal lounges and dining rooms on each of the units. There are two units within the home which accommodate people living with dementia. One is on the ground floor and accommodates up to 15 people and the other is on the first floor accommodating up to 16 people. Both have communal living areas with kitchen facilities and a dining area.

There was a manager in post; however this person was not registered. 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.

We observed staff interactions with people were warm and engaging. It was clear that staff knew people well. People responded well to staff and appeared comfortable in their company.

We found most areas of the home were clean however; some items of furniture such as arm chairs in the communal lounges were stained and had dried food on them. Carpeting in communal areas also looked stained. We looked in people's bedrooms and found people had personalised their rooms with ornaments and photographs.

We saw people's safety was being compromised in a number of ways. We saw areas of the home were left unsupervised at times. This was in the communal living and dining areas of the home. Staff told us this was due to the dependency of people living at the home. Staff we spoke with also told us they were concerned about the staffing levels in place at the home at night. They said they were worried about people's safety.

We looked at information which showed there had been a high number of falls at the home between July and December 2014. The majority of these were at night and unwitnessed by staff.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

We saw six members of staff who were new to the service were working 'shadowing' shifts on the units however; there were no records of their inductions. These included regular staff and staff employed to work on the bank. We were told that when agency staff were used to cover shifts they did not receive an induction to the home.

We received information of concern during our inspection regarding the storage of chilled items in the fridges of the kitchenette areas of the units. We were told that staff were opening items and labels with dates of opening were not being attached. We looked in the fridge on the ground floor residential unit. We saw a number of items were open with no dates of opening on.

We looked at the medication administration records for 15 people. We saw there was no guidance in place for staff to follow regarding the administration of 'as required' medicines.

We saw there was a plan in place for activities to be facilitated by care staff at the home. However, staff told us that the dependency of people living at the home was high and there were not enough staff to facilitate activities in line with the plan.

We spoke with seven members of staff who were able to tell us about the action they would take if they suspected someone was at risk of abuse. They told us they had attended safeguarding training and were aware of the policies in place regarding reporting concerns.

Relatives we spoke with told us they were concerned about activities not taking place and the level of personal care their relative was receiving. One relative told us "They used to be immaculate and now they aren't even having a shave. It's sad to see them like this." Another relative told us "Activities are virtually non-existent. I can't see how staff can do them, there's only two on each of the units. People look fed up. I know my relative would really appreciate some 'one to one' time."

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

Inadequate

The service was not safe.

Dependency levels of people in the home meant staff were not always able to supervise the communal areas.

There were no checks in place regarding the storage of food items in fridges in the kitchenette areas.

A high number of falls had occurred at the home. Analysis of this showed the majority of these had occurred at night in people's rooms and were unwitnessed by staff.

Is the service effective?

Inadequate

The service was not effective.

There was no evidence to show how staff that were new to the service were inducted to their role.

The home provided care for people living with dementia however; we found there was no guidance in place or best practice being followed with regard to this.

Staff who were trained in Mental Capacity Act 2005 and medicines did not receive refresher training. We were told their competency was checked by the home manager however, there were no records to show this had taken place.

Is the service caring?

Requires Improvement

The service was caring.

Staff engaged with people in a warm manner which was observed throughout the inspection.

People said their privacy and dignity was respected. We observed staff knocking on doors and asking permission before entering rooms. People who requested support from staff were given support in a discreet manner.

Some of the people living at the home did not have their personal care needs met.

Is the service responsive?

Inadequate

The service was not always responsive.

People's care plans did not contain information which was personalised. Care plans did not provide staff with clear guidance on how to meet people's needs.

There were processes in place for people to express their opinions and views on the service provision however; we found that actions were not taken in response to issues raised.

Summary of findings

A plan of activities was in place however; people we spoke with, including staff and relatives told us these were not being facilitated. We saw people were unoccupied and unsupervised for periods of time.

Is the service well-led?

Inadequate

The service was not well-led.

The manager in post at the time of the inspection was not registered with the Care Quality Commission.

Some staff we spoke with told us the provider and manager of the home did not listen to their concerns regarding changes to deployment of staff within the home.

The provider had a quality assurance system in place however; we saw there were no completed audits.

Greenacres

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.

We inspected Greenacres on 8, 19 and 20 January 2015. The visit was unannounced. The inspection team consisted of one adult social care inspector, a specialist advisor with a background in governance, a specialist advisor with a background in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One adult social care inspector returned to the home for the second and third day of the inspection.

At the time of this inspection there were 61 people living at the home. During the inspection we spoke with nine people who lived at the home, two visitors who were relatives of people living with dementia, 10 members of staff, the manager, a peripatetic manager and the head of operations.

Because some of the people who lived at the home could not always tell us their experiences of living at Greenacres, we also 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.

We spent time with people in the communal areas observing daily life including the care and support being delivered. We looked at four people's care records, seven recruitment files and six staff training records, as well as records relating to the management of the service. We looked around the building and saw some people's bedrooms, bathrooms and communal areas.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service.

Inadequate

Is the service safe?

Our findings

Our last inspection took place in June 2014 and, at that time; we found the service was not meeting the regulations related to staffing. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked and found improvements had not been made.

During this inspection we spent time on three of the four units of the home. We saw the environment was well maintained and we saw documentation which showed that regular checks were carried out on the fire alarm system, emergency lighting, fire extinguishers, nurse call system and water temperature within the home. We looked at records which showed that if repairs were required to the environment, these were recorded and when completed they were signed to show the action had been carried out. The manager told us they had access to maintenance staff employed by the provider who visited the home three days a week and if urgent repairs were required, there was an on call system available to ensure repairs were carried out promptly. This meant people were cared for in a suitably maintained environment.

Staff we spoke with had a good understanding of how to protect vulnerable adults. They told us they knew people well and believed they would know if there was neglect or abuse taking place. Staff told us they would speak to senior staff or the manager immediately if they had any concerns ensuring they made accurate documentation of this. They said they were sure action would be taken but knew how to escalate concerns both internally and externally if action was not taken. Staff told us they were aware of whistleblowing procedures and how to use them if they had concerns. All but one of the staff we spoke with said they had received training in safeguarding adults. One of the staff members was new to the service and told us their training was booked. We looked at the training records of 53 staff who worked at the home. The records showed 20 of 53 staff were out of date with safeguarding adults training and four staff had not received safeguarding adults training. This meant staff may not be aware of how to raise concerns about abuse and their role in the protection of vulnerable adults.

During the inspection we saw that kettles and toasters which were being used to make people's breakfasts and hot drinks during the day were left out and were within reach of people. This was in communal areas of the home where people were unsupervised. The meant people were at risk as the kettles and toasters were hot. We spoke with one member of staff who ensured all of the units put them away. However, on the second day of our inspection we saw they were out on the worktops again on two of the units. We looked in four people's care records and found there were no risk assessments in place regarding access to hot kettles and toasters. This meant people were not safe as they had access to items which may cause harm or injury.

We received information of concern during our inspection regarding the storage of items in the fridges of the kitchenette areas of the units. We were told that staff were opening items and not labelling items with dates opened. This could put people at risk. We looked in the fridge on the ground floor residential unit. We saw a number of items were open with no dates of opening on. We spoke with the manager who said they had not been able to find out how long the items had been open for. Also, there were other food items being stored in plastic containers which were covered with Clingfilm and these also did not have dates on. We saw a document was available for the purpose of recording checks on the fridges however, we were told by the peripatetic manager these had never been used at the home. There was also no documentation available to show the temperatures of the fridges on the kitchenette areas were being monitored. This meant people were at risk of having access to food and drink which may cause them to become unwell. The peripatetic manager told us they would ensure checks were carried out on a regular basis.

The information we received also stated there were issues with domestic staff using the wrong coloured buckets when cleaning bathrooms and kitchens. We looked in the cupboard where this equipment was stored and saw there were two signs which explained the correct colour coding system in place however, the signs were flat on a shelf and therefore not in the sight of staff. The manager told us they would ensure the signs were put back up.

We spent time on the three of the four units within the home observing care practices. On one of the units which accommodated people who were living with dementia, we saw there were two staff on duty. One staff member was a senior carer and they were responsible for administering medicines on two units in the home, three times per day.

Is the service safe?

This meant they had to leave the unit. When this happened a 'floating' member of staff was allocated to cover for them. We observed periods of time when the communal areas of the unit were left unsupervised. This occurred when one or both staff members were carrying out personal care for people and administration of medicines was taking place. We saw people were left unsupervised by staff for periods of time. During these periods we saw there were a number of people who required assistance from staff. For example, one person was walking around and talking to two people who were sitting in the dining room area and were sleeping. The person kept telling them to wake up. One person became agitated by this and tried to get up out of their chair to leave the table. They were unable to get themselves up without assistance. Another person was calling out saying they needed to use the toilet. This meant staff were not available to respond to people's needs, to offer direct supervision or to maintain people's safety.

We looked at the way staffing levels were determined at the home. The manager told us they used a dependency tool. They said they looked at people's care records on monthly basis to gather information about people's needs. They would then determine the level of staffing needed within the home. The results of the 'monthly dependency tool' showed that each of the four units accommodated people with varying levels of dependency. For example, one unit accommodated up to 16 people. We saw three people required support from one staff member with meals and four people required two staff for their mobility needs which included the use of a hoist. There were two people who experienced 'sleep disturbance', one person required support of two staff with personal care needs and eleven people required support from one staff member with their personal care needs. However, we saw the staffing levels for all of the units within the home were the same. This showed staffing was not arranged according to the needs of people living at the home.

We looked at the number of falls which had occurred in the home since our last inspection in June 2014. From July 2014 to December 2014 we saw there had been 122 falls. 76 of these had occurred at night with 52 being unwitnessed by staff. 53 of the falls had occurred on the units which accommodated people living with dementia. The peripatetic manager told us there had been a high number of staff sickness during December 2014 which had led to the increased use of agency staff. We asked what actions had been taken to prevent the number of falls. We were told there were 23 people who had equipment in their rooms to alert staff of their movements at night. We saw one unit had eight people who were deemed at risk of falls. The peripatetic manager told us new equipment had been ordered which would hopefully alert staff earlier. They said this action was being taken as a preventative measure, but it had not reduced the number of falls. Rotas showed there was one member of care staff on duty at night on each of the four units between 10pm and 7am with the support of a night care manager for the home. This showed the number of staff on duty at night did not ensure people's safety.

We spoke with seven staff who worked at the home. All of the staff we spoke with told us they thought the home needed more staff on duty during the day and at night. One staff member said "If we had two staff on each unit with a floating senior on each floor during the day we would be able to get to everyone. It's just madness at the moment." Another staff member said "The managers are talking about how we manage our time. They say they are concerned about this but they have just given us even more to do." Staff we spoke with also told us that being able to have their breaks without worrying about leaving their unit was also an issue. They said this was because people's dependency was high. One staff member said "When it's really busy I just nip off for ten minutes. I don't want to leave as I know what it's like on your own." Another staff member said "I'm not taking a break most shifts as it's just too busy. There is no good time to leave the unit." One staff member told us they had worked some nights at the home and found that night staff were not having breaks as their units could not be covered.

We spoke with the manager and the peripatetic manager who told us they thought the staffing levels at the home were fine at the moment and that they would increase them if they thought the need was there. We discussed the feedback we had from staff and a person's relative regarding one person who had become more challenging and aggressive towards staff. Staff told us "X (the person) can become very aggressive, lashing out at staff when we try to do any personal care, so we take our lead from X." We observed the person sitting in nightclothes in the communal lounge at 11am on the first day of our inspection. Staff told us the person responded better to male staff. We looked at rotas from November 2014 to January 2015 and saw that male staff were not always on duty. At night there was often no male member of staff in the building. Staff told us if the person refused to go to bed

at night they had to be left wherever they chose to sit. This was because the one staff member on the unit would not be able to get them to bed even with support of other staff in the building. Staff told us they often found it difficult to manage the person's behaviour and believed more staff would help. We saw the dependency tool stated the person required one staff to support them with their personal care needs. It was clear from our observations and feedback from staff that one staff member was not enough. We spoke with the person's relative who told us they visited the home regularly. They said there were times when they had visited and they had seen the staff struggling to deliver personal care to their relative. They also told us they believed more staff were needed. We looked at the rotas from November 2014 to January 2015 and saw there had been no increases in staffing. The manager and the peripatetic manager both confirmed this.

This demonstrated a continual breach of Regulation 22 (Staffing) 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.

We looked at the arrangements in place for the storage, ordering and disposal of medicines and found these to be safe. People's medicines were stored securely in a locked room. We saw staff were recording the temperature of the room on a daily basis. This showed medicines were stored at the required temperature. We saw there was an up to date medication policy in place which all staff had signed to say they had read. We looked at the medication administration records (MAR) for 15 people. We saw the MAR's in use were printed by the dispensing pharmacy and included details of the person concerned such as their GP and their date of birth. We saw there was one missed signature which meant it was not clear if the person had received their medication. The peripatetic manager checked on this and found the medicine had not been given and there was no reason recorded. They told us they would look into this.

We found that where people were prescribed 'as required' medication, adequate guidance was not in place for staff to follow. We found documents in with the MAR's which told staff if the person was able or unable to request 'as required' medication. The documents also required the symptoms the person may experience when they needed 'as required' medication. However, for people who were unable to tell the staff when they needed these medicines we saw there were documents which had not been completed. This meant staff may not know the signs to look out for when a person was experiencing pain. This also meant people may be at risk of not receiving their medicines when they needed them.

We saw photographs of people were in place with their MARs however, some of the photographs were of poor quality and would not ensure the recognition of the person concerned. Staff told us they were often tasked with administering medicines on units which they did not usually work. We saw there were care plans in place for people regarding their medicines which provided staff with guidance on how the person liked to take their medicines. However, the care plans were stored in another area of the home. This meant they were not accessible to staff at the time medicines were being administered.

This breached Regulation 13 (Management of medicines) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We spoke with the peripatetic manager who told us all mandatory training which included dementia awareness, safeguarding, conflict resolution, moving and handling, health and safety, food hygiene and infection control was completed on induction and refreshed annually. We were told staff also completed other training which was relevant to their role however, this training was not refreshed. This included Mental Capacity Act 2005, safe handling of medicines and care planning. The peripatetic manager told us the manager should be assessing staff's competency at supervisions and through appraisals and record this within staff files. We looked in the personnel files of six staff members and found there was no documentation to support this. One of the senior carers on duty during our inspection had last completed medication training in 2012. They were responsible for the administration of medicines for up to 30 people three times per day when they were on duty. We spoke with the senior carer who told us they had not attended any refresher training on the administration of medicines. This meant the home could not ensure staff were competent to perform aspects of their roles.

We looked at the training records of 53 staff who worked at the home. We saw a number of staff who were out of date with their mandatory training. For example, 46 out of 53 staff were out of date with their fire training, 24 out of 53 staff were out of date with dementia training, 23 out of 53 staff were out of date with food hygiene training, 25 staff were out of date with infection control training and 24 staff were out of date with health and safety training, 16 staff were out of date with manual handling training with six staff records showed the staff had never attended manual handling training. We spoke with the peripatetic manager who told us they were aware of the issues regarding training. They said the provider had changed the provider of staff training so this had led to some staff not having their training update. This meant people living at the home could not be assured that staff caring for them had up to date skills they required for their role.

We spoke with the manager who told us a number of new staff had been recruited to the service. We spoke with one of the staff members and they told us they were completing an induction. We looked at a blank induction document and saw it had been designed to be carried out over a six month period. The manager would then formally sign off the induction as complete. We were told that part of the induction included new staff 'shadowing' more experienced staff to gain an insight into the requirements of their role. The new staff had been working 'shadowing' shifts at the home. We asked to see the induction documentation for the six staff and the manager told us they did not know where they were. They told us they had not asked anyone to complete the inductions with staff. This meant there was no evidence to show how new staff had been inducted into their role. The peripatetic manager told us they would deal with the issue and printed off new induction booklets for each of the staff members.

This breached Regulation 23 (Supporting workers) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home provided care for people living with dementia on two units and had a 'Dementia Care' policy in place. However, this did not refer to any national guidance or best practice on which the home based the care they provided. We spoke with two staff who worked on the ground floor unit for people with dementia. They had a good level of understanding of how to support people living with dementia. They told us they had completed 'Dementia awareness' training but had also looked at resources in their own time regarding caring for people with dementia. We spoke with a further five staff at the home who also told us they had received 'dementia awareness' training. However, none of the staff we spoke with were unable to tell us about a model of care in use at the home, the National dementia strategy or NICE guidance (National Institute for Health and Care Excellence) with respect to caring for people with dementia.

We saw that a member of staff working on one of the units did not have a uniform on. They told us they had worked at the home for a number of weeks and said it had been ordered. The staff member would have been more recognisable to people living with dementia as a staff member if they had a uniform on. We saw that on both of the units the signage in place was not adequate for people living with dementia. The ground floor unit had direct access to a garden/courtyard area. However, the unit upstairs had a 'key pad' in place on the door. People living on this unit were not able to leave the unit on their own

and had to approach staff and request to be taken down to the ground floor of the home. This meant people were being restricted in their movements around the home and garden areas.

We saw that all of the four units within the home were decorated in the same way and had a homely feel however, when we spoke with the peripatetic manager and the manager of the home they were unable to tell us of any adaptations which had been made on the units which accommodated people living with dementia. We spoke with the head of operations about this and they told us they were aware there was no reference to national guidance or best practice on which the home based the care they provided within the dementia care policy in place at the home. They were unable to give any examples of where the provider had utilised nationally recognised care interventions. For example, promoting choice and providing support and design and adaptation of accommodation. Due to the lack of implementation of best practice guidance the provider could not assure themselves they were meeting the required standards regarding dementia care.

This demonstrated a continual breach of Regulation 9 (Care and welfare of service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we last visited the home in June 2014 we were concerned that people living on two of the units were being restricted in their movements around the home and gardens. On this visit, the manager showed us records which showed they were working through applications for people living at the home. However; at the time of our inspection the home had only made three Deprivation of Liberty applications to the local authority. We saw no action had been taken with regard to giving people more freedom within the home. This meant people living on the ground floor and first floor dementia units were at risk of having their movements restricted due to a key pad requiring a code being in place on the door and only staff members having the codes. People living on the ground floor and first floor residential units were able to use the lift freely to access the ground floor and garden areas. This meant people were at risk of being deprived of their liberty.

We looked at the training records in place at the home and saw that 36 out of 53 staff had received training on the Mental Capacity Act 2005. However, we saw the training some staff had attended was dated 2010, 2011 and 2012. We were told by the peripatetic manager that mental capacity training was not mandatory and no refresher training had been provided since these dates. Information provided in the PIR stated 'Update information on MCA/ DoLS will be communicated to staff' and 'All staff attend training on Mental Capacity Act'. However, we saw these actions had not been carried out at the time of our inspection. Therefore, the provider could not assure themselves that staff had up to date knowledge they required including the development of common law relating to mental capacity and deprivation of liberty.

We looked at the care records of four people and saw there were documents in place for the purpose of obtaining the person's consent. In one person's care records we saw the person had their mental capacity assessed in relation to decision making. The assessment stated they had capacity to consent and make decisions. However; we saw the person's relatives had signed the consent documents in place for the person and no reason for this had been recorded. In another person's care records we saw they had been assessed as having fluctuating capacity. We saw the person had signed their own consent documents. The home had made a deprivation of liberty application for this person and the documentation we saw stated they did not have capacity. This showed the records for this person did not contain accurate information.

This breached Regulation 18 (Consent to care and treatment) 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.

Staff told us people were supported with accessing health care services such as GPs, dentists and opticians. We saw evidence to support this in the care records we looked at. This showed people living at the home received additional support when required for meeting their care and treatment needs.

We observed mixed experiences of mealtimes at the home. During our observations on the ground floor residential unit we saw staff were very caring in their approach and offered continuous support to people to eat their meal. For example, "X (the person) wake up sweetheart, its lunchtime." Staff said this whilst stroking the person's back gently. "Stew and dumplings today ladies and gentlemen,

Inadequate

Is the service effective?

smells nice," "Do you want a cushion to sit you up a bit?" "X (the person) open your eyes for me; we've got some scampi for you." "X (the person) sweetheart, will you open your eyes for me; have a drink for me, we've got some apple juice." We saw despite the efforts of the staff member the person did not wake up to eat their meal. One person made attempts to leave the dining room without finishing their meal. We saw staff made several attempts to get the person to stay and finish their meal and even offered them an alternative or a dessert.

However, during lunch time on the ground floor dementia unit we saw there were three staff who were not available to all of the people who required support with eating their meal due to the domestic tasks they had to complete. For example, one member of staff was serving people's food on to plates, another staff member was serving drinks to people and the third staff member was assisting one person to eat their meal. During the meal time we observed five people who needed assistance with eating their meal.

One of the staff members was trying to make sure people were eating their meals. They did this by going from person to person giving verbal prompts. We saw one person was trying to leave the table without having eaten their meal. One of the staff members gave the person reassurance and sat with them. The person began to eat their meal. Another person was falling asleep with their meal in front of them. When one of the staff members was available, they gave verbal prompts of encouragement. The person pushed food onto their fork but did not eat. By the end of the meal time the person had been prompted twelve times by the staff member and had only eaten a very small amount. This meant the level of intervention by staff did not ensure the person ate their meal. We looked at the dependency tool and saw it identified this person was 'independent' under 'food and drink' which meant the person did not require support. This meant some of the people living at the home were at risk of not receiving an adequate level of nutrition.

Requires Improvement

Is the service caring?

Our findings

We observed staff interactions with people throughout the inspection and saw that all of the staff who worked at the home displayed warmth, kindness and compassion to each person they supported. Some of the people living at the home were able to tell us their views on the care they received. One person told us "The staff are good. They treat me with respect." Another person said "The staff are caring, if you want anything they will get it for you." Another person told us "The staff are very nice. I get on with all of them."

We saw staff approached people with respect and support was offered in a sensitive way. We heard staff explaining tasks to people before they went ahead with any support. For example, we heard staff explain what they were about to do before they moved a person using a hoist. On the unit for people living with dementia, we saw when staff were in the communal areas of the unit they asked people how they were and if they were feeling ok. Where people had fallen asleep at the table, staff put their arm around them and spoke softly to them to wake them up. We saw staff knelt down and touched people's hands when speaking to them. We spoke with staff who told us they had worked on the unit for a long time and knew people well, how they liked to be approached and receive support. This information was reflected in the care records we looked at. This demonstrated the benefits of having some staff working on dedicated units within the home.

It was clear to us that staff knew people well and did not miss opportunities to engage with people. For example, on the ground floor unit for people living with dementia we saw staff were very skilled when interacting with people. They did this in a way which engaged and encouraged the person to be as involved as they could be in activities of daily living. We spoke with the relative of one person who lived on this unit who told us they had nothing but good things to say about the staff. "The staff are lovely, just lovely. They are really good with people. They don't do it for show it's just how they are. I just wish there were more of them they are so busy. I don't know how they manage sometimes." We spoke with two members of staff who worked on the unit. Their knowledge of people's preferences and routines showed they knew people well. They were able to describe how they changed their approaches with people in order to support them as well as they could in aspects of their personal care. This showed that people were supported and cared for by staff who knew them.

We asked staff if people were able to have a bath or a shower whenever they would like one. We saw a diary which held records of the number of baths and showers people had in a week. We saw that some people were not having a bath or a shower at least once a week. For example, week commencing 5 January 2015 showed six out of 13 people did not have a bath or a shower and week commencing 12 January 2015 showed eight out of 14 people did not have a bath or a shower. We spoke with the relative of person who lived on another unit within the home. They told us they were concerned their relative looked unkempt. They said "My relative used to be immaculate. When we arrived today they were wandering around with their trousers undone. They haven't had a shave today and that's not how they used to take care of their appearance. Another family member visited last week and said our relative had the wrong glasses on. It's just not right. I also have seen an entertainer here once but I don't actually know how my relative is spending their day." This demonstrated the home did not meet all people's personal care needs.

This demonstrated a continual breach of Regulation 9 (Care and welfare of service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

When we visited the home in June 2014 we were concerned about the lack of activities in place for people. The provider sent us an action plan telling us what improvements they were going to make. We checked on this during our inspection and found that there had been some improvement. This involved some people being taken out on trips into the local area and entertainment taking place at the home. However, on this inspection we saw people were spending periods of their day not engaged in any meaningful activities. For example, on one unit nine people were seated in the communal lounge area after breakfast. They remained in the same chairs throughout the morning. We saw no activities were offered to people.

At lunchtime staff assisted people to the dining tables in the adjoining kitchenettes. When people had finished they were assisted back to the lounge area, to the same chairs. We spoke with one person who told us they were ok but felt a bit fed up. They said "I'm ok, I feel a bit fed up. Every day is the same." We spoke with two people about activities on offer to them. One person said, "I don't like to join in. A nice chat is enough for me but you can see how busy they are." Another person told us "I've always loved dancing. They do play music but it's the same one they have on and you get sick of it." This meant these people did not have adequate social stimulation to support their emotional or mental wellbeing.

The home did not employ dedicated activity staff. The administrator told us they organised activities for people however, they were not given any extra time for this. We saw a weekly activity plan which showed activities were planned for each unit and these were facilitated by the care staff on duty. We looked at the 'activities folder' where staff told us they recorded people's engagement in activities. For all of the people on one of the units we saw no activities were recorded for the two days before our visit which was a weekend. One person had activities recorded for two days which stated 'Very sleepy'. We spoke with staff and they told us they could not find the time to do activities. One staff member told us "We know we are expected to do them but when we've done everything we have to do there is just no time. We are busy with the care side of things and making sure records are done." Another staff member told us "It's almost impossible to do activities. They haven't even given us training. If someone told you to do an activity on '60's clothes' what would you do?"

We asked the manager if any training on activities had been undertaken by any staff that worked at the home and were told none had. We looked at the resources available for activities and were shown a room called 'activity lounge'. This contained two clothing rails full of people's unclaimed clothes and Christmas decorations. The manager was unable to find the new purchases made by the provider for activities at the home. We saw in a cupboard on the unit for people living with dementia there was a puzzle game which had 'Help your child develop' written on the box. We were shown evidence which showed an order had been placed for 'children's dominoes'. This meant the home was not appropriately meeting the social needs of people who lived there.

This demonstrated a continual breach of Regulation 9 (Care and welfare of service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records of four people. We saw they contained 'life history' documents for the purposes of gathering information to ensure personalised care was provided. A life history document enables staff to understand and have insight into a person's background and experiences. One person's life history had not been completed. We were told the person had a 'memory folder' in place however; we saw there were areas which had not been completed. These included 'My personality', 'My attitude to life is', 'These are my beliefs and expectations of life in general'. Had these documents been completed they would have provided staff with a good understanding of what was important to the person. In the same person's care records we saw they had a care plan in place for 'hygiene and personal care needs' which stated 'needs two staff to use hoist.' However, we saw there was no guidance for staff to follow regarding the use of the hoist. We saw another person had a care plan in place which stated staff were to use 'distraction techniques' if the person became distressed. There was no guidance in place for staff to follow regarding this. This meant both people were at risk of receiving inappropriate or unsafe care due to the lack of guidance in place within their care records.

Requires Improvement

Is the service responsive?

We looked at the way the home responded to concerns and complaints. The manager told us people had access to the complaints procedure as there was a copy in each person's room. The complaints procedure gave clear timescales for dealing with complaints. We looked at the complaints log and saw the home had received three complaints since our last inspection in June 2014. We saw all of the complaints had been investigated however, one of the complaints did not show evidence of being resolved. We spoke with the manager who had undertaken the investigation and they told us the complainant was not satisfied with the findings. However, the complainant had not wanted to take their complaint any further. This showed the complaints people made were responded to appropriately.

Inadequate

Is the service well-led?

Our findings

The manager in post at the time of our inspection was not registered. We spoke with them about the changes they were hoping to implement at the home. This involved moving staff around the home. They said this was for the purpose of ensuring staff developed a range of skills required to meet the needs of all of the people living at the home. We saw the manager had drawn up an agenda and invited staff to comment. There were handwritten comments such as "staffing levels", "rotating staff around units", "carers too busy with dependency level to do any activities", "communication between staff and senior management", "proper assessment on residents and put them in right place." The finalised agenda for the meeting we saw contained 29 points which the peripatetic manager told us they needed to raise with staff.

The planned staff meetings were time limited and aimed at groups of staff within the home for example, senior care assistants, deputy managers and kitchen staff. We spoke with staff and received mixed feedback regarding the staff meetings. One staff member told us they had no problem with the proposed moves of staff, they said "I'm happy to work anywhere in the home, it's good to get to know people." Another staff member told us "I think it will be to people's detriment if they move us around. People have got to know us. If you're living with dementia, new faces are not what you need. I'm not sure they've (management) thought it through." Staff told us they had been spoken to about the plans but they believed they had not been listened to when they had voiced their opinions. We spoke with the manager who told us the rotation would be carried out in a very planned way and they had consulted staff. However, when we asked to look at the minutes from the consultation meetings held we saw no staff comments had been recorded. This suggested the home did not promote an open culture where staff felt supported when they raised concerns about matters which affected their role or people who used the service.

We saw the provider had a quality assurance system in place which consisted of audits which required completion on a monthly basis by the manager. This included audits of accidents, falls, floor management folder, bed rail usage, complaints monitoring, pressure sore, weight loss action plan, medication, infection control, catering, care plans, satisfaction surveys, CQC/safeguarding notifications and the dependency tool. This was then checked by the area manager on their monthly compliance visit. We asked to look at the information but were told by the peripatetic manager that due to the change in management of the home none of the audit documentation from July 2014 to December 2014 could be located. We asked if there was any evidence to show they had been completed. The peripatetic manager said there was no evidence to show the audits had been carried out. This meant there was no evidence to show how the home had assessed and monitored the service provision.

We saw the area manager had carried out 'Key lines of enquiry compliance' visits to the home in October 2014. There were a number of actions identified however; we saw there was no action plan developed from this. This meant the visits the provider had put in place did not ensure improvement of the service.

We saw there were systems in place to enable people living at the home to comment on the service provision. We saw that regular residents meetings were held at the home. We looked at the minutes of the meetings from August 2014, September 2014 and October 2014. No residents meetings had been held since October 2014. We saw that issues raised by people were not being resolved. For example, the issue of people's clothing not being returned following being laundered had been raised at every meeting. The manager had responded stating there were new labelling systems being put in place. However, we saw that at the next meeting the issue was raised again. We asked to look at action places from the meetings to identify who would ensure actions were taken. We were told this did not happen and people were given feedback on actions taken. This meant people's concerns were not acted on.

We looked at a range of surveys which had been completed by some of the people living at the home. These included cleanliness, social activity, laundry, privacy and dignity, food and menu and additional services. However; we saw none had been completed since October 2014. The manager also told us that analysis of the results of the surveys had not been carried out. It is good practice to analyse trends identified from survey results as part of continuous quality improvement and any lessons learned should be shared with staff.

We found no evidence to show analysis of accidents or incidents including safeguarding incidents which occurred

Inadequate

Is the service well-led?

at the home had been carried out since our last inspection in June 2014. Trend analysis of incidents that may result in harm to people allows changes to their care and treatment to be made where needed.

This demonstrated a continual breach of Regulation 10 (Assessing and monitoring the quality of service provision) 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **12.**—(1) Care and treatment must be provided in a safe way for service users. (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; (g) the proper and safe management of medicines;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11.—(1) Care and treatment of service users must only be provided with the consent of the relevant person. (2) Paragraph (1) is subject to paragraphs (3) and (4). (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9.—(1) The care and treatment of service users must— (a)be appropriate, (b)meet their needs, and (c)reflect their preferences. (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (b)designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; (h)making reasonable adjustments to enable the service user to receive their care or treatment;

The enforcement action we took:
Warning Notice to be met 1 April 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a)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); (b)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;

This section is primarily information for the provider

Enforcement actions

(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d)maintain securely such other records as are necessary to be kept in relation to—

(i)persons employed in the carrying on of the regulated activity, and

(ii)the management of the regulated activity;

(e)seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

The enforcement action we took:
Warning notice to be met 1 April 2015.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

The enforcement action we took:
Warning notice to be met by 1 April 2015.