Care Quality Commission

Byron Lodge (West Melton) Limited

Byron Lodge Care Home

Inspection report

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West Melton
Rotherham
South Yorkshire
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Ratings

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

Overall summary

The inspection took place on 29, 30 October and 5 November 2015 and was unannounced. The service was registered with the CQC in March 2015. We completed a focused inspection of the service in July 2015, following concerns raised. We looked at whether the service was safe and caring and breaches of legal requirements were found. We issued a warning notice because people were not protected against the risks associated with the unsafe use and management of medicines. Other breaches were that people did not receive care or treatment in accordance with their wishes, and their privacy and dignity were not always respected.

After the focused inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches.

We began the inspection on the 29, 30 October and 5 November 2015 by checking that they had made the improvements in regard to the warning notices issued

Summary of findings

and the breaches found at our last inspection. We found that no action had been taken to address the issues relating to medication and limited action had been taken to resolve the breaches.

Byron Lodge is a care home providing accommodation for up to 61 people. It is situated in the area of West Melton, approximately six miles from Rotherham town centre. It provides accommodation on both the ground and the first floor and has parking to the front of the building and a secure accessible garden at the rear.

The home was split up in to four units; Shakespeare and Ruskin providing nursing care and Wordsworth and Browning providing residential care. At the time of our inspection there were 53 people using the service.

The service had a manager in post at the time of our inspection, who had worked at the home for approximately ten weeks. However, they were not 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 this inspection we looked to see if improvements had been made since our last inspection in July 2015. We saw no improvement in the areas previously identified and we found further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included that records did not always reflect that medicines were given correctly, and as prescribed. Medicines records were not always clearly completed to show the treatment people had received. We found a number of gaps in the records we reviewed, and there was evidence to suggest people had not been given their medicine, but no reason had been recorded as why these medicines had not been given.

We looked at six support plans and found they contained risk assessments. These were documents which outlined any risk associated with the person's care. They explained the risk presented, but guidance on how to minimise the risk was limited, and the care we saw being offered by staff was not in line with these assessments.

During our inspection we observed staff working with people and found there were not enough staff, with the right skills and experience available to meet people's needs.

We looked at the training record provided to us by the manager. It showed that a number of staff had not received mandatory training. This meant they may not be able to safely deliver care to people who used the service.

We observed lunch on the first day of inspection on Ruskin unit. Lunch was soup, sandwiches and cakes. Staff put food down in front of people; and did not provide any choice.

We found the service was not always meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). One person we met wanted to leave and had restrictions placed upon them. We saw no DoLS was in place for this person and no evidence that an application had been made.

There was a lack of social interaction with people living at the home. We saw that people were not always involved in decisions about their care, or given choice.

People's support plans were not always clear and precise. Care delivered was not always in line with people's care plans.

The service had a complaints procedure and people felt able to raise concerns, but they were not sure if anything was actioned.

Staff did not know their responsibilities and there was a lack of leadership within the home.

We saw some systems in place to assess and monitor the quality of the service. However these had not been developed and actions raised had not been addressed.

We saw no evidence that people were routinely asked for their views about the service. People told us they had not been asked to give feedback about the service.

We raised our concerns with the nominated individual of the service and visited the home on 5 November 2015 to conclude our inspection and to see if they had taken any immediate action to address the issues we found on the 29 and 30 October 2015. We found that a regional manager had been employed and was based at the home offering leadership and guidance to staff about

Summary of findings

actions they needed to take to meet acceptable standards. The staff numbers had been raised by one on the Shakespeare unit and also the Ruskin unit. Two nurses had also been recruited to work at the service.

We found seven breaches of The Health and social care Act 2008 (Regulated Activities) Regulations 2014, and continued breach of Regulation 12(1), (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking action against the provider, and will report on this at a later date.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

Medicines were not always given correctly, as prescribed. Medicines records were not always clearly completed to show the medicines people had received.

There were not enough staff available to meet the needs of the people living at the service.

Risks related to people's care were not always assessed and monitored to ensure they received safe and appropriate care.

The service had a safe recruitment system in place.

Inadequate

Is the service effective?
The service was not effective.

We looked at the training matrix provided to us by the manager. It showed gaps in mandatory training for a number of staff. This meant they may not be able to safely deliver care to people who used the service.

One person repeatedly requested to leave the home. However, we saw no evidence that there was an authorisation in place to deprive the person of their liberty or that this had been applied for. This showed a lack of understanding around MCA and DoLS.

People's preferences and dietary requirements were not always taken into consideration at meal times.

Inadequate

Is the service caring?
The service was not always caring.

People told us that staff were caring. However we saw that staff were very task orientated, and showed a lack of understanding about people's needs.

People's likes and dislikes were recorded in some care plans but were not always upheld by staff.

Inadequate

Is the service responsive?
The service was not responsive.

People's support plans were not always clear. Care delivered was not always in line with people's care plans.

Inadequate

Summary of findings

The service had a complaints procedure and people felt able to raise concerns.

Is the service well-led?

Inadequate

The service was not well led.

Staff did not know their responsibilities and there was a lack of leadership within the home.

We saw some systems in place to assess and monitor the quality and safety of the service. However these had not been developed and actions that had been raised had not been addressed.

We saw no evidence that people were asked for their views about the service.

We raised our concerns with the nominated individual of the service and visited the home on 5 November 2015 to conclude our inspection and to see if they had taken any action to address the issues we found on the 29 and 30 October 2015. We saw that action had been taken.

Byron Lodge 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 29 and 30 October and 5 November 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, two pharmacy inspectors 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.

Before our inspection, we reviewed all the information we held about the home. We also spoke with other professionals about their experiences of the service.

We spoke with the local authority and Healthwatch Rotherham to gain further information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We spoke with eight people who used the service, and nine people's relatives. We observed care and support in communal areas and also looked at the environment.

We spoke with four care workers, the deputy manager, the home manager, regional manager, and the nominated individual. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at six people's care and support records, including the plans of their care. We looked at systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement. We looked at seven staff files including care workers, ancillary staff and nurses.

Inadequate

Is the service safe?

Our findings

During our last inspection in July 2015, we found the provider to be in breach of Regulation 12(1), (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have appropriate arrangements in place to safely manage the administration of medicines. As part of this inspection we checked to see if improvements had been made. We continued to find concerns in a number of areas, including those we had found previously.

We looked at 11people's medication administration records (MAR) on the nursing units during the visit and spoke with two nurses who were covering both units. Medicines were not always given correctly, as prescribed. We found that one person had not received their medicines to manage their medical condition at the right time on four occasions out of six over two days. They had also not been given doses at all on 11 occasions in the last month. A second person who requring medicines had received their morning doses up to two hours late. A further person was prescribed an antidepressant once daily, but the MAR had been signed twice daily. The dose was not recorded accurately, so we could not be sure that it had been given as prescribed.

Medicines records were not always clearly completed to if people had received these. We found a number of gaps in the records we reviewed with no reason recorded why medicines had not been given. This meant it could not be confirmed whether people had been given their medicines as prescribed. Three audits carried out by staff at the care home in October had also identified gaps in the recording of medicine administration but no effective action had been taken to address this.

Records of the receipt and balance of medicines were not always correct meaning medicines could not be accounted for to ensure their proper and safe management. National guidance states that staff should have at least an annual review of their skills, knowledge and competence with regard to medicines, but we saw no evidence of this being implemented.

We found a lack of information to guide staff how to safely administer when required medicines. The recording of whether one or two tablets were given when variable doses of pain killers had been prescribed was not always documented.

We looked at three MARs on the residential units and spoke with the senior care workers on both units. One person had been assessed by a senior care worker as capable of self-medicating; however we found large quantities of medicines dating back several months in their bedside locker. We were told they didn't always take their medicines but no further risk assessment had been completed. A second person who was also self-medicating had not used their inhaler for over two weeks when it was prescribed twice daily. When we spoke with the resident they did not know what the inhaler was prescribed for. This meant residents were not being adequately supported to take their medicines as they had been prescribed.

We looked at records for one person on the residential unit who had been prescribed a medicine used to prevent blood clots and found that records of blood tests were not complete, so staff could not be sure of the correct dose. This is contrary to current guidance, and put the person at risk of harm from not being monitored correctly or receiving the incorrect dose.

Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were appropriate arrangements in place for the destruction of controlled drugs. However, on the nursing units the door was left open with the keys in the medicines trolleys on more than one occasion during our visit.

Medicines which required cold storage were kept in a fridge within the medicines store rooms. Fridge temperatures had not been recorded correctly every day as recommended in national guidance. On two occasions in the last month the fridge temperature had fallen outside normal range but no action had been taken. This meant there was a risk medicines kept in the fridge would not be safe to use. We found expired medication stored in the fridge on the nursing units and there was also a urine sample stored along with the medicines. On the residential units we saw a medicine that should have been stored in the fridge had been left in the medicine trolley at room temperature. This had also been identified in August in an audit carried out by the home's current pharmacy provider.

Inadequate

Is the service safe?

This was a breach of Regulation 12(1), (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection in July 2015, we judged the provider to be in breach of Regulation 12(1), (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not always planned and delivered in a way that ensured people were safe. As part of this inspection we checked to see what improvements had been made. We continued to find concerns in this area.

We looked at six support plans and found they contained risk assessments. These were documents in place which outlined any risk associated with the person's care. They explained the risk presented, but guidance on how to minimise the risk was limited and we saw that care being offered was not in line with these assessments. For example, one person had a 'dehydration indicator' risk assessment, which showed they were at risk of dehydrating. Fluid charts were in place indicating that the person had drunk very little. A referral had been made to appropriate healthcare professionals. However, there were no evaluation of the person's fluid intake and during our observations we saw very few drinks offered to the person.

This was a breach of Regulation 12 (1), (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that there had been a high turnover of staff over the last 9 weeks which had resulted in an increased use of agency staff. This meant often staff were unfamiliar with how to safely deliver care to people. We were told that 11 care staff 2 nurses and the handyman had all left the service. The manager told us that every effort was now taking place to fill the vacant posts.

We observed staff and found they did not have enough time to meet people's needs. One care worker said, "One person on our unit likes to use the commode but it's easier and quicker if they use the bottle. I say there is a long queue and you are at the end of it, so I have five minutes and you will have to use the bottle." This showed disregard for the person's wishes but also identified that they did not have enough time to ensure people were assisted in the way they preferred.

We also noticed staff shortages at mealtimes when there were not enough staff to ensure people's needs were met. This led to staff being very task focused and were not always considering people's preferences. For example, we visited Shakespeare unit at 9.15am and saw there were no staff visible; three people were sat in the dining room. Two people had their breakfast in front of them. One person told us, "I don't like cereal it goes soggy." When we asked what they would like they said, "I always have toast and marmalade." There was no staff to ask if this could be provided. Twenty minutes later we saw a care worker come out of a room, they told us there was only two care staff on the unit and one nurse was between the two units upstairs. The nurse was not on Shakespeare at the time but was administering medication on Ruskin unit.

A care worker told us that they had 14 people on the unit and 13 required two staff to support them for personal care and moving and handling needs. They also explained that only four people regularly got out of bed. One care worker told us, "We are very short staffed, we have to work task orientated. We have to." They knew this approach was not person centred and was institutionalised. However, they explained if they did not do this people did not get washed or get their meals. Another care worker told us, "We go room to room to get people washed; we cannot be in the lounge as well." The care worker also commented, "With only two staff we can only do basics. It is wrong." A relative we spoke with said, "They (the staff) have done really well for my family member and still do, but there is only two staff on duty (Shakespeare unit) and sometimes there are agency nurses who don't seem to know what they are doing." Consequently this person felt the permanent staff had to spend more time showing them what to do. One person who used the service said, "If I press the buzzer at night they are here like a shot, although in the day it sometimes takes longer." Other comments about the care staff were that they were, "Grafters," "Caring," and "Trying their best in difficult circumstances."

On 29 and 30 October 2015 we observed staff working with people and found there were not enough staff, with the right skills and experience available to meet people's needs. In addition, an agency nurse was on duty on Shakespeare unit, who had never been to the home before, but was expected to be in charge of the day to day running of the unit. In Ruskin unit there was an agency nurse who had worked at the home on four previous occasions. The agency nurse on Ruskin unit was left to handover to the agency nurse on Shakespeare unit, but did not know all the information that was required to be passed on.

Inadequate

Is the service safe?

They told us, "I can only tell them what I know." The home manager and the deputy manager were present in the home but did not give the new agency nurse a hand over. Care staff we spoke with told us there was agency nurses used 'all the time.' We looked at the rota for week commencing 26 October 2015. This showed two nurses should have been on duty each morning, one nurse every afternoon and one nurse at night. The rota showed that for four days of that week agency nurses were used to cover all day shifts. For the other three days there was an agency nurse used at least one shift per day. The night shifts were covered by permanent staff. The care staff told us the use of agency nurses put more pressure on them, as the agency staff did not know the people who used the service.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Staffing)

We found the home had robust recruitment and selection procedures to ensure suitable staff are employed to work at the home. The manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check and references had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. We confirmed this when we looked at seven staff records. We also checked that the nursing staff were fit to practice and they had the skills and competencies to work as a registered nurse. We saw confirmation of this.

All new staff completed an induction programme. However, one of the files we looked at showed the member of staff had only attended a basic in house induction which gave an introduction into the service, including things like uniforms, orientation of the building and how to notify if they were unable to attend work. We saw the staff member had attended fire training and moving and handling training. Additionally, there was no evidence that this member of staff had received any formal staff supervision since they commenced work at the home on 30 June 2015. The manager told us that the staff member had missed the formal three day induction, and was currently absent from work.

We saw the provider had a policy in place to safeguard people from abuse. The staff we spoke with were knowledgeable about how to protect people and how to report abuse. We spoke with people who used the service and their relatives. One person said, "I feel perfectly safe with all the staff here." Relatives we spoke with told us they had no reservations about leaving their relative at the home. One person said, "There is definitely no mistreatment."

Although people and their relatives expressed confidence in the service, during our inspection we found two safeguarding concerns, which we reported to the local authority. Additionally, when we spoke with the manager about recording safeguarding concerns and the outcomes, we found that they did not have a procedure in place to log safeguarding concerns and did not identify any lessons learned to prevent similar issues.

Inadequate

Is the service effective?

Our findings

We spoke with people who used the service and their relatives and they did not raise any concerns about the skills and knowledge of the staff. For instance, one relative said, "The staff know what they are doing." However, we found that staff did not always have the appropriate knowledge to meet people's needs. We asked some care workers about dementia care and found they did not have a good understanding of this area of their work.

We spoke with staff about the training they received and they told us training not very accessible. One care worker said, "I have not done training for a while, can't remember when I last did any." Another care worker said, "I have worked here for about three years and did some training in my first year, not done much since."

We found that staff did not received appropriate one to one supervision meetings with the manager to ensure they had the skills and competencies to deliver care safely. We saw a matrix developed by the manager that showed some supervision's had recommenced. However, prior to the new manager taking over staff supervision had not been completed for a number of months. The manager showed us blank appraisal forms which they told us were to be distributed to staff. The manager confirmed that no appraisals had been undertaken. Annual appraisals provide a framework to monitor performance, practice and to identify any areas for development and training to support staff to fulfil their roles and responsibilities.

We spoke with staff about how often they received supervision sessions. One care worker, who had worked at the home for three years said, "I had my one supervision and this was done by the previous manager."

We looked at the training matrix provided to us by the manager. The training matrix showed a total of 86 staff were employed to work at the home. The record showed gaps in mandatory training for a number of staff. This meant they may not be able to safely deliver care to people who used the service. For instance, the record showed that 18 staff had not undertaken training in safeguarding people, 23 staff had not completed infection prevention and control training and 39 staff had not completed the basic dementia awareness training. We also looked at 7 staff training files and found certificates that confirmed when training had been completed. However, one of the certificates we saw in staff files we looked at, told us that six core subjects were covered in one day of training. This meant the training could not be sufficiently detailed to be effective.

This was a breach of Regulation 18(1) (2) (a) Staffing; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed mealtimes throughout the home. During breakfast on Ruskin unit we saw five people in the dining room. There was one care worker assisting someone to eat and a nurse who was administering medicines. One person kept standing up and walking away from the table and, as other care workers entered the dining room they tried to sit the person down and eat something. The person did not respond to this. We looked at this person's care plan and found the person required one person to assist them, as they responded well to a consistent approach. Their records showed they were also losing weight and were being weighed on a weekly basis, although the information on their food and fluid charts was limited. The care plan also stated that the person required fortified food. From our observations we found their care plan was not being followed.

We observed lunch on the first day of inspection on Ruskin unit. Staff put food down in front of people; this did not give people a choice. Lunch was soup, sandwiches and cakes. These could have been taken around for people to choose. However, the sandwiches and cake were placed on plates and given to people.

We saw that staff thickened people's soup with breadcrumbs. They told us this was easier for people to eat. It was not clear if people required thickened food and all soup we saw served was thickened this way.

One person tipped their tea over themselves and the floor, staff cleaned the floor and said to the person, "It didn't go down you did it?" they did not check. We saw that most of the tea was spilt on the person's clothing. The person was also not offered another drink.

Overall, staff on the unit did not provide a positive meal time experience for people. This put people at risk of not receiving adequate nutrition and was not conducive to a positive experience for people living with dementia. We saw there was a lot of food wastage, as people did not eat much. The meal time experience was, chaotic,

disorganised, and was not individualised or person centred. This meant people did not experience a positive meal time and did not provide a calm environment for people to be encouraged to eat and enjoy the experience.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Meeting nutritional and hydration needs).

We observed hot drinks being served on Wordsworth unit with biscuits mid-morning. One person was offered a yogurt instead, as they had a tendency to choke. One person told us, "I love the food here they give you some right good stuff. We usually have soup and sandwich at lunch time and a cooked meal later in the day."

Overall, there were no menus on view for people to look at and tables were not set with appropriate condiments. However, when we returned on the third day of our inspection we found improvements had been made in this area. We saw the dining room on Ruskin unit had appropriate table covering and condiments and they were set ready for breakfast.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. Staff we spoke with had some understanding of the Mental Capacity Act 2005.

We found the service did not always meet the requirements of the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards (DoLS) are part of MCA 2005 legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. One person we met wanted to leave the home and had restrictions placed upon them. No DoLS authorisation was in place and this had not been applied for. The manager or staff had not recognised or considered that this person may be being deprived of their liberty and that an application to a Supervisory Body may be required. This meant staff lacked understanding about the legislation and were unaware of the correct procedures to follow to ensure people's rights were protected.

We looked at six people's care plans and found there were consent forms in place for things such as the use of photographs and how the person wanted to be supported. However, four out of the six forms were blank.

This was a breach of Regulation 11 (1) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Consent).

We looked at care plans and spoke with people and found they had access to their own G.P and records we looked at showed that people were supported to access other health services as required such as dietitian, speech and language therapist and tissue viability nurses. One relative said, "We have had the doctor out a few times and at one point a nurse was coming in daily." Another relative said, "If a GP was required one would be summons." During our inspection we spoke with a healthcare professional, who said, "The staff have followed my instructions and that is evident from what I have seen today."

Inadequate

Is the service caring?

Our findings

During our last inspection in July 2015, we found the provider to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people's care did not always meet their needs and reflect their preferences. As part of this inspection we checked to see if improvements had been made. We continued to find concerns in a number of areas, including those we had found previously.

We received mixed opinions from the people we spoke with. For instance, one person who used the service said, "The staff are as good and kind as they can be." Another person said, "The staff are very caring." However, with regard to privacy and dignity they told us, "I have problems with the staff on nights who are changing me, when they are both men." One person's relative said, "I couldn't say anything wrong about the care, they are good and respect [my relative's] privacy and dignity.

Another person who used the service said, "If you want a bath you have to book it a week in advance." We saw the staff kept a 'bath rota' with 11 people on the list. However, this record showed that three people had only had one bath in the month of October 2015, and two people had not had a bath at all in that month. This showed an institutional practice, and also identified that regular baths were not available for people.

We observed staff interacting with people throughout our inspection, this included at meal times. We found staff were very task orientated, and that this was mainly due to the lack of staff and we saw staff and care provided lacked dignity and respect for people who used the service. This did not provide a caring environment and did not show that positive, caring relationships were being developed.

We observed one person who had difficulty in communicating. They used a piece of paper and pen to explain what they wanted. We asked staff if they could help us to find out what the person was trying to say. A care worker entered the room and after a short while and said, "He's off on one." About the person who was trying to communicate. This was a negative and dismissive comment and showed a lack of understanding and support for the person.

We looked at people's care plans on Shakespeare unit. We sat in an open plan office at 12.40 we heard a care worker shout, and this seemed to be directed at a person who used the service. We went to look and the care staff were hoisting the person into a wheelchair to take them to lunch. The care worker shouted, "Why did you do that?" Then said again, in a very loud voice, "Stop nipping. That hurts." We observed the person was grabbing at the care worker's arm; it looked like this was for support, rather than to cause intentional harm. We did not see the care workers attempt to calm the person or explaining what was happening.

During lunchtime we observed one person trying to take the cake case from the cake so they could eat it, but they were struggling. None of the staff present acknowledged the person or offered any support.

Another person stood up and tried to leave the table. Another person who sat at the table with them told staff, "They want the toilet." A care worker asked the person to sit back down. We then saw the person urinated on the floor. Care workers were slow to respond and eventually went and got the person's walking frame so they could go to the toilet. After lunch and approximately 15 minutes after they had been taken to the toilet, we saw the person trying to get out of the toilet. There were no staff present, and the person was naked.

We observed one person just prior to lunch who told staff, "I am thirsty I want some water" and, "I am hungry." The care staff told the person they would get a drink when they went into the dining room. When we entered the dining room we saw that the person had been given a drink of juice, rather than the water they had asked for. This had been thrown on the floor and a care worker was mopping it up.

The person had previously told staff they were hungry. They proceeded to crawl across the floor to the food counter. There was finger food available. However, staff did not offer the person any food. Staff did not engage with the person. They walked around them to serve food to others. A care worker asked us from across the room if we know about the person and proceeded to share information with us about the them, in a way that everyone else could hear.

We saw one person who was assessed as needing one to one staff hours provided for two and a half hours each day in order to meet their needs. At the time of our visit this person's needs were not being met, as the additional hours were not being provided. The manager told us it was

Inadequate

Is the service caring?

difficult to get extra staff for just two and a half hours each day. They had not considered or looked into other ways of providing the support. A representative of the local authority told us that funding had been approved for this person's one to one staffing and it should be provided. The manger told us they were not aware the funding had been approved.

One care worker we spoke with said, "As long as they [people who use the service] are clean and fed that's all that matters." This showed lack of understanding around people's personal preferences. We saw care plans did not always contain information on the person's likes and dislikes and with the exception of one file, did not include life histories. The person's file which included this information had been completed by a family member.

Clocks throughout the home displayed the wrong time. For example, one clock had stopped at quarter to ten and a person said, "I could do with a drink." Someone replied, "It's nearly time for lunch." To which the person said, "It's only quarter to ten." When in fact it was five minutes to twelve. This was very disorientating for people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Person centred care).

Inadequate

Is the service responsive?

Our findings

We spoke with people who used the service and their relatives about the support they received from staff. Most people felt the staff were good at what they did, but said there were not enough of them.

We looked at six care plans and saw they required updating. Some information contained within them was out of date and did not reflect current advice from professionals. For example, we saw one person had been seen by a physiotherapist who recommended the person should be moved using a hoist, but if compliant could stand with minimal support after explanation. They also advised that the person should have a sensor mat in situ when they sat in the lounge, due to being at risk of falls. We observed two care workers move this person inappropriately and without communicating. The sensor mat was not put in place. This showed the professional's advice was not followed. We spoke with the manager who had also witnessed this and who agreed the person should not have been moved that way. We looked at the person's care plan and found it had not been updated to reflect the guidance given by the physiotherapist.

Another person's care plan indicated that they displayed behaviour which may challenge the service. This person had behaviour charts in place, the purpose being to write down any trigger, the behaviour shown and what happened afterwards. These were not consistently completed and several gaps were noted in recording. We asked staff about their understanding of completing the forms and they were unsure. There were no evidence that the information contained in them was evaluated. Therefore, it was difficult to determine why they were completed.

We saw from people's weight charts that several people were losing weight. People's weights were being checked on a regular basis, but there was a lack of evaluation and follow up on professional's advice. For example, one person who had lost 6.3kg in seven weeks had been referred to the speech and language therapist and a treatment plan had been set up. The care plan stated that the person should have fortified diet including snacks. The person's fluid intake was poor and the care plan indicated that staff should offer regular fluids throughout the day. Food and fluid charts should also be completed. We looked at the food and fluid charts and found they recorded very little and that quite a lot of diet had been refused or not eaten. We observed the care of this person and the support they were receiving during mealtimes. We saw food offered was inappropriate to the diet required. For example, at breakfast the person was given toast which had gone cold and only one mouthful was eaten. At lunch time the person was offered two quarters of a sandwich and a bun, with a cup of tea. These were not eaten as no staff were around to support the person. There was a lack of evaluation of the food and fluid charts and no one appeared to take responsibility for the person's continued weight loss.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe care and treatment).

The service employed an activity co-ordinator. However we saw very little social interaction taking place. The activity that did take place was generally in the entrance area of the home. We also saw 9 people playing bingo in the entrance area. This excluded other people on the units, who could have watched, if the activity had taken place on a unit. During our visit we did not see any organised activities taking place on the units.

Relatives we spoke with said there were parties from time to time, such as at Easter and Christmas, but they were unaware of other activities. However, one relative said, "I might have missed them."

We saw people who used the service were sleeping in the lounges for most of the day. One person said, "All we can do is sit and cal (local vernacular for talk)."

We saw that copies of the home's complaints policy were displayed in the entrance area of the home. The policy displayed stated complaints would be responded to in 15 days. However, the guidance in the complaints file we looked at stated complaints would be responded to in 21 days. We brought this to the attention of the manager.

We looked at the complaints file and found it disorganised and difficult to assess if complaints had been responded to in a timely manner. The file also contained grievances made by staff, safeguarding investigations and contract concerns notifications from the local council. This made it difficult to establish how many complaints had been received from people who used the service or their relatives. We noted that a number of contract concerns were in relation to staffing levels and people's needs not being met.

Inadequate

Is the service responsive?

We spoke with people who used the service and their relatives and one relative said, “No one has ever said anything about how to complain, but I would come down and see the manager if I wanted to say anything.” Another relative said, “I will certainly tell staff if something is amiss.”

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the service had a new manager, who had been in post approximately ten weeks, and they were not 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.

The manager was supported by a deputy manager and a team of nurses and senior care staff. We were told that the company had recruited a regional manager, who was due to commence employment on 2 November 2015, to support the home manager.

We spoke with people who used the service and their relatives and most people felt they had someone they could talk to about the service. Although it was not clear that any actions were taken as a result of what people had said. A lot of people commented about the service being disorganised. The lack of staff, and the lack of consistency of regular staff had impacted on this.

From our observations we saw staff lacked leadership and direction. Staff struggled to deal with some situations and there was no one around to guide and direct them. Some staff were new to the service and some were agency staff, which was a contributing factor. Staff were unsure of what was expected of them and lacked basic information necessary in order to complete their role effectively.

We saw that no action had been taken to address issues raised at our inspection in July 2015. Issues around medicine management, person centred care, risk management and privacy and dignity were still outstanding and required resolution in order to ensure people were safe and well cared for.

During our inspection we saw personal information left lying around on the units and accessible to anyone walking by. For example, on Shakespeare unit files contain food and fluid charts and positioning charts were kept outside each person's room in the handrail. We also saw personal information such as weight charts on the wall of the office on the other units... This showed a lack of confidentiality for people's personal information.

We asked the manager what systems were in place to ensure policies and procedures were followed. The manager showed us a series of files which had been set up in her office. However, they were lacking in content. The manager also showed us audits which had been completed by Care Plus Group, a company purchased in to audit the service. These audits had been carried out in April, August and September 2015 and highlighted similar concerns to the ones we raised. The August audit was rated as amber, meaning action had been started. Both April and September 2015 audits had been rated 'red' meaning action was required but not started. For example areas to address included staff supervision, complaints policy to be reviewed, menus to be developed in accessible formats, care plans to change over to new paperwork, and a client participation group to be implemented. These areas had not been addressed. We raised this issue with the manager and regional manager.

In addition to these audits the manager and deputy manager had completed some audits of care plans. However, we saw that two of the files we looked at had been audited and no concerns had been highlighted, when there were blank forms in the file and a lack of detail regarding the person's care.

We saw evidence that a relatives' and residents' meeting had taken place in August 2015 and this had been mainly to introduce the new manager. There were no indication of other meetings scheduled. Additionally, relatives we spoke with told us they had not been asked to complete any feedback or questionnaires or satisfaction surveys. They were also not aware that any residents' and relatives meetings had taken place.

This was a breach of Regulation 17 (1) (2) (a)(b)(c)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Good governance).

People we spoke with generally felt they could approach staff or the manager. However, one person who used the service told us that they did not know who the manager was, but had spoken with the deputy manager. Another relative told us they felt unable to raise issues with the manager, although they had many concerns about the care of their relative.

On the second day of our inspection we raised our concerns about the service with the nominated individual of the company and asked for reassurances that action

Inadequate

Is the service well-led?

would be taken to ensure people were safe. This was taken seriously and we were sent an action plan informing us of what action they would take and how they intended to respond to our concerns. We visited the home on the 5 November 2015 to conclude our inspection and to check that immediate action had been taken. We found the nominated individual had taken action. The new regional manager was in post and based at the home to provide leadership and ensure staff were supported and that people's needs were being met. We were informed that a staff meeting had taken place on the 4 November 2015 and had been well attended. Staff had been fully updated with our findings and informed of the action required to bring the home up to an acceptable standard.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1), (2) (f) (g) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not managing medicines safely. The provider did not take proper steps to ensure each person who used the service received care that was safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider did not have suitable systems in place to ensure there were sufficient numbers of qualified, skilled and experienced persons employed to meet people's needs. The provider did not have suitable arrangements in place in order to ensure that persons employed for the purpose of the regulated activity were appropriately supported in relation to their responsibilities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of people who used the service in relation to the care and treatment provided to them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have suitable arrangements in place to ensure people's dignity and privacy were maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider's systems were not effective in monitoring the quality of service provision.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider did not ensure that people who used the service were protected from the risks of inadequate nutrition and dehydration.**

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.