Crimson Care Limited

Colne Valley Residential Home

Inspection report

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Milnesbridge
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Date of inspection visit: 29 October and 8 November 2014
Date of publication: 23/03/2015

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection on 29 October and 8 November 2014. The inspection was unannounced and was the first inspection of this service since the provider registered with the Care Quality Commission in August 2013.

This means that this was the first inspection of the service under the new provider.

The service provides accommodation for up to 20 older people, some of whom may be living with dementia. On the day of our visit there were 14 people living at the home. Accommodation at the home was provided in single ensuite bedrooms set over three floors.

The registered provider is also registered with the Care Quality Commission as the registered manager of the

Summary of findings

service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were being put at risk because robust procedures and arrangements were not in place to keep people safe. There were issues with the safety of the premises including very hot water, blocked fire exit, lack of security, unsafe furniture and poor standards of cleanliness and infection control.

Medicines were not stored securely and were not always administered as prescribed.

Accidents and incidents within the home were not audited and notifications had not been submitted as required to Local Authority Safeguarding, the Care Quality Commission or the Health and Safety Executive.

People's needs had not been assessed and effective up to date care plans were not in place. People who lived at the home had not been involved in their care planning and there was no evidence of review of care.

These are breaches of regulations 9, 11, 12, 13, and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed that the majority of staff's approaches to people who lived at the home were kind and respectful and people told us that staff were good. However, staff had not received appropriate training or support from the provider. Staff were unaware of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. None of the staff had received training in caring for people living with dementia and some staff had not received appropriate moving and handling training.

There were not enough staff available to meet people's care needs as staff were assigned to domestic duties within their care shifts.

Staff had not been recruited safely and some staff had not had any induction training.

These are breaches of regulations 21, 22 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Complaints had not been managed or responded to appropriately.

There were no systems in place for assessing and monitoring the quality of service provision, the safety of the service or for gathering people's views.

There was a lack of leadership and the Care Quality Commission had received concerns about the attitude and conduct of the registered provider/manager.

These are breaches of regulations 10 and 19 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.

People who lived at the home were not protected because staff were not recruited or trained appropriately. Care records were not in place to make sure staff knew how to meet people's needs.

Accidents and incidents were not managed and safeguarding incidents had not been recognised as such and had not been reported appropriately.

Environment risks had not been identified and there were poor standards of cleanliness and infection control.

Medicines were not stored securely and were not always administered as prescribed. This meant there were risks to people's health and safety.

Is the service effective?

Inadequate 

The service was not effective.

Staff had not received appropriate induction or training. There was no system for supporting staff through supervision or appraisal.

Staff had no understanding of the the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). This meant that people who lived at the home had not been assessed for their ability to make decisions about their care or their lifestyles.

People had not been involved in the planning of their care and were limited in the choices they could make.

Is the service caring?

Requires Improvement 

The service was caring. However, we found this was due entirely to the attitude of the care staff. People who lived at the home told us the care staff were very good.

We saw some examples of a lack of respect for people's dignity, for example staff not changing people's clothing as required and not offering choices.

Care records were not maintain securely and none of the staff had undertaken training in maintaining people's dignity, person centred care or principles of care and confidentiality. None of the care records were based on a person centred approach.

Is the service responsive?

Inadequate 

The service was not responsive.

People's needs, preferences or abilities had not been assessed and people were not involved in the planning of their care.

Summary of findings

There was no formal system in place for gaining the views of people who used the service.

Complaints had not been addressed appropriately.

People were not able to tell us about an appropriate programme of activities and some people told us they were bored with little to do.

Is the service well-led?

Inadequate

The service was not well led.

The provide/manager demonstrated little understanding of their responsibilities as registered person under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Accidents, incidents and safeguarding issues had not been reported appropriately

There were no effective systems in place to monitor the quality of the service.

The home was poorly organised and although staff responded to people's needs as they arose this was not supported by any robust care planning or staff training.

There were no processes in place for leadership within the home when the manager was not available. There were no senior care staff employed and nobody was identified as being in charge of care shifts.

The Care Quality Commission had received a number of concerns from professionals relating to the attitude and conduct of the provider/manager

Colne Valley Residential 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.

This inspection took place on 29 October 2014 and was unannounced.

The inspection team consisted of two Adult Social Care 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. The area of expertise of the expert-by-experience was caring for older people and those living with dementia.

Before the inspection we reviewed the information we held about the service. This included looking at any concerns we had received about the service and any statutory notifications we had received from the service. We usually send the provider a Provider Information Return (PIR) before the inspection. 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 had not sent a PIR to the provider before this inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with eleven people who were living in the home, two care staff, the activities co-ordinator, the cook and the registered provider/manager.

We looked in detail at three people's care records and parts of care records for another three people. We observed care in the communal areas of the home. We looked at four staff recruitment files and staff training records. We also looked at records relating to the management of the service including policies and procedures. We looked round the building and saw people's bedrooms, bathrooms and communal areas. We also looked in the laundry room.

We received information from five health or social care professionals who had concerns about the conduct and attitude of the provider/manager . All stated the provider/ manager had failed to work with them in the best interests of the people who lived at the home.

Inadequate

Is the service safe?

Our findings

All of the people we spoke with who lived in the home told us they felt safe. Several people mentioned instances when one person had been verbally and physically aggressive toward staff and other people who lived at the home. Most of the people we spoke with felt the staff had coped well with these incidents, although one person said, "We just coped with it, we had to. There wasn't anyone else there when it happened."

We looked at care records and saw that assessments of people's needs had not been carried out in a manner which would protect their safety. For example, one person told us they needed the hoist for bathing. There was no risk assessment available for this in their care file. We looked at the care records for a person who had been displaying some behaviours that challenge. We found there were no assessments of the person's mental health and no care plans to instruct staff how to support and safeguard the person and others. One person's care file did not contain any assessments or care plans at all. This was despite other records showing the person was affected by a number of physical conditions including very poor eyesight, which could compromise their safety.

We saw that one person who lived at the home had ten separate accident records of falls in a three month period. No risk assessment or care plan had been developed for this person in this regard.

We saw one person whose records we had looked at had lost 4kg in weight in the last three months. This person was unwell at the time of our visit and needed their food and fluid intake recording. We looked at the charts in their room including intake/output records and found they were all blank. A member of care staff said they were supposed to be recording what this person ate, but did not know where old records were or why the ones in the room were blank. This meant that this person's diet and fluid intake was not being monitored effectively in response to their illness and recent weight loss.

The manager told us there were no senior care assistants at the home. When we asked the manager who was in charge of each shift they said there was not an identified staff member in charge. We asked how this might affect emergency procedures such as fire alarms when there was no one in charge to manage the situation. The manager said they did not think this was an issue. We saw from the rota that a member of care staff was identified as being 'on call' for the night shift each day. We did not see any evidence that staff had been trained to deal with any emergencies that might occur.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the records relating to an incident when one person had been physically aggressive towards another. We saw that staff had called the police as a result of this incident. We asked the manager if this incident had been referred, as required, to the local council's safeguarding team. The manager said it had not.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the manager what training staff had taken with regard to keeping people safe. The manager provided us with print outs which showed that staff had completed the on-line 'Social Care TV' training.

We spoke with three members of staff about their understanding of safeguarding people. They all demonstrated a good understanding of what constituted abuse and said they would report any suspicions to the manager.

We saw records of other incidents where another person had abused other people who lived at the home and made threats to their safety. We asked the manager if these had been reported to safeguarding. The manager said they had not. We asked the manager if they had reported these incidents to the Care Quality Commission as required by regulation 18 of the Registration regulations of the Health and Social Care Act. The manager said they had not.

We looked at accident and incident records. We saw that none of the accident/incident forms had been signed as reviewed by the manager. We asked the manager if they had analysed these accidents and incidents. They said they did not. We asked the manager if they had notified the Care Quality Commission, as required by regulation, of accidents where injury was sustained. The manager said they had not.

A staff member told us of an incident in the home when they had sustained an injury which required surgery. We also saw a record for another staff member who had sustained fractured ribs in the course of their work. We

Inadequate

Is the service safe?

asked the manager if they had made the required reports to RIDDOR (**Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)** The manager said they thought they had but they were unable to provide evidence of this. They confirmed to us that they completed the referrals the day after our inspection visit.

We looked at the systems in place for the receipt, storage and administration of medicines in the home. We saw medicines were not kept securely as the medicine trolley and fridge were located in an area of the home which was easily accessed from outside. When we entered this area we saw the external door was wide open, there were no staff present and neither the medicine trolley or fridge were secured to the wall. The provider confirmed to us that the trolley and fridge had been secured to the wall the day after the inspection. We noted that confidential records relating to people who lived in the home were also kept in this area and were not locked away.

We saw the majority of medicines had been booked in safely and staff signatures were in place. However, we saw some anomalies with the booking in of one person's Warfarin tablets. We also noticed a device in the medicine trolley which needed to be fitted internally by a doctor. There was no record of the device having been prescribed or received by the home.

We saw the MAR (Medication Administration Record) provided information for staff about each medicine. We saw staff made a mark on the MAR to indicate they had taken the medicine to the person and then signed when the person had taken it. This was good practice. However, we noted that tablets for one person had been signed as taken at 08.24. Yet we had seen the person still had their tablets in a medicine pot at 09.30 when we spoke with them in their bedroom.

We noted there were a number of occasions when people had not received their medication as prescribed. The explanation for this was that there had not been sufficient time lapse since the previous dose. For one person this meant they had not received their medicine as prescribed on eight occasions in a two week period. We saw another person had been prescribed a course of antibiotics. Staff had made a note on the MAR which said they had not seen the prescription and therefore the antibiotics had not started until the following day. We saw a further person had not been given their pain relieving medication for four days. The only explanation for this as recorded on the MAR was "ran out."

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we looked around the home we found several areas were not clean. Some bedrooms had a strong odour and there was a lack of appropriate hand washing facilities for staff. One person was being cared for in their room as they had gastro-enteritis. We did not see adequate hand washing facilities for staff in this room and there was no care plan to inform staff how to manage the infection risk. In another person's room we saw the remnants of the previous day's evening meal on a tray on the floor. Some of the furniture in the lounge area was not clean and smelled unpleasant.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found there were not sufficient staff to meet people's needs. Care staff told us they did the cleaning when a cleaner was not available. We saw the rotas identified one of the care staff for cleaning duties and identified which areas they should clean. We saw nine bedrooms had to be cleaned each morning and each afternoon. The staff member on cleaning duties also had to manage the laundry. This meant staff had to complete cleaning, laundry and care duties within their shift.

One staff member told us they did not feel they had time to spend with people when they were covering cleaning and laundry tasks as well as providing care. With three care staff on duty at a time this meant only two staff were available to provide care to people when one was doing cleaning and laundry.

We observed there were occasions when staff were not available in the dining room or the lounge area. We noted that call bells were not available to people in these areas. When we asked one person how they would attract staff's attention if they needed them, they said, "I would just have to shout."

Inadequate

Is the service safe?

One person who lived at the home had been waiting for their breakfast for an hour. They told us staff were very busy and they thought they needed more staff. Another person said "They're a bit over-pushed. They could do with a few more."

This is a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our tour of the building we identified a number of areas which could pose a risk to people living at the home. In one person's bedroom we saw a new washbasin and vanity unit had been put in place. The unit had not been secured to the wall and could easily be pulled over. In another room we saw an extension lead taped over the top of the door frame and hanging down the side of the door with the plug for the television.

We tested the water temperature in one toilet and three washbasins in people's bedrooms. We recorded a temperature of 60.1 degrees Centigrade in all of these outlets. The recommended safe temperature is 43 degrees centigrade. This meant people were at risk of scalds.

Some areas of the home were being prepared for decoration by the handyman. We saw that a fire exit sign had been removed and that all the external fire doors had a hook and catch on top of the door which meant the door could not be opened easily. We also saw empty boxes partially blocking a fire escape route. We have asked the fire authority for their advice in this regard.

We saw some rooms had large amounts of windows. In some areas the glass was not well secured within the frame due to wear and tear and there was no indication that the windows were made of safety glass. We were aware of one severe injury caused by a glass panel falling out when a member of staff went to open a door.

We saw the laundry could be accessed by a steep staircase. The door to this staircase was not locked and there was no warning of the staircase.

In the laundry we saw workmen knocking down a wall. None of the clean clothing had been covered whilst this work was ongoing.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw workmen in various places within the home. One of them told us they did a lot of work for the manager. We saw these workmen had access to all communal areas and unlocked bedrooms. We asked the manager if DBS (Disclosure and Barring) checks had been taken for the workmen. The manager said they had not.

We looked at recruitment records for four staff. We saw that an enhanced DBS check had not been taken for a member of care staff. One person did not have any references and two others had only one appropriate reference. None of the files we looked at contained an application form, a job description, a job offer letter, a contract, interview notes or start date. In two of the files there was no evidence of the person having followed an induction programme and in the other two there was minimal information about induction. This meant that staff were not safely recruited.

This is a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

We talked to people who lived at the home about their feelings as to whether the staff knew how to care for them. All of the people we spoke with said the staff did know how to support them to meet their needs. One person said, "They're very patient and they talk to me all the time."

We looked at four staff files to see what induction process new staff followed. In two of the files there was no evidence of the person having followed an induction programme and in the other two there was minimal information about induction. The manager told us that the core standards induction training was not in place at the home.

None of the staff we spoke with had received any supervision or appraisal from the manager. The manager confirmed to us that they had not done this.

We asked the manager for records relating to staff training. The manager provided us with fifteen records although we saw from the rota there were nineteen staff employed at the service including the manager. All of the training had been done through 'Social Care TV' online training.

Of the fifteen staff records provided we saw that four members of staff had not completed any moving and handling training, only one person had completed training in continence promotion and one person had completed training in nutrition.

One person had completed training in Deprivation of Liberty Safeguards (DOLs) but no staff had completed training in the Mental Capacity Act 2005. We spoke with two staff about MCA and DOLs, one said they had never heard of them and the other said they thought they might have had training but did not know anything about it.

This meant that staff had not received the training they needed to support them in carrying out their role safely and effectively.

This is a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

The manager told us that all of the people living at the home had capacity. However, we did not see any assessments of capacity. When we asked what would happen if a person who lived at the home wanted to go out for a walk, one member of staff told us they would ask people's relatives if that was alright but said staff would have to go with them. This meant that staff lacked understanding of the Deprivation of Liberty Safeguards (DoLS) that may need to be in place should they need to restrict a person's liberty in order to ensure their safety.

Staff told us each day two people who lived at the home were asked if they would like to go to the nearby garden centre for lunch. We saw this was initially paid from petty cash but was then charged to the person. We also saw records that people had been charged for a take-away fish and chip meal at the home. This meant people were paying for meals in addition to those already paid for within their fees. We did not see any evidence that people had been assessed to have the mental capacity to understand this.

We saw all of the care plans in place included the statement 'Discussed and agreed with resident' However we did not see any evidence to show this had been done. We did not see any evidence of consent being obtained from people who lived at the home with regard to their care.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with were generally positive about the food they were served and said they did have a choice at mealtimes. We saw although people were offered choice of meals, choice was sometimes restricted. For example, meals were served ready plated, meaning that people did not get a choice of vegetables or whether they had gravy. Also coffee was served from a jug which already had milk in it, meaning people could not choose how much milk they had or whether they had milk at all.

Two people we spoke with said that food was sometimes not warm when it was served. One said "It's a bit disappointing but you can ask them to zap it in the microwave for you." Another said "I didn't say anything because I don't like to make a fuss. I ate it as it was." Other people told us "I've had the soup – it had bits of everything in it. I don't know what it was but it was nice." And another said "The food is going downhill"

We saw staff were not always available in the dining room to enhance the dining experience for people and to make sure people were managing and enjoying their meals.

Inadequate

Is the service effective?

People told us they could get drinks when they wanted them and that biscuits were served during the afternoon. However one person said “Sometimes you have to watch it though because the dog (belonging to the manager) pinches them.”

When we asked people who lived at the home and visiting relatives, if they found it easy to access health professionals they were not always positive. One visitor said “(my relative) wanted to see a dentist and we asked about it. That was two weeks ago and nothing has happened.” A person who lived at the home said “I’m disappointed not to have seen a physiotherapist. When I left the hospital they said I would see one but I haven’t heard anything about it since I came here.” All of the people we spoke with felt that a doctor would be called if needed.

Prior to our inspection we had received concerns that people may not have received medical attention in a timely manner. However the care records we saw showed that the involvement of GPs and district nurses had been requested when a need had been identified.

Other concerns received were that staff had not always let families, who assisted their relative with hospital appointments; know that appointments had been sent to the home or that appointments had been changed. During our visit we saw five letters to people who lived at the home informing them of appointments. We did not see anything to show that either the person themselves or their relative had been informed of the appointment.

Requires Improvement

Is the service caring?

Our findings

All of the people we spoke with were positive about the staff and the way that they were treated. One person told us about times when a member of staff came to talk to them. They said "It's lovely – she brings the outside world in with her. We talk about her family and things like that."

None of the people we spoke with were able to tell us about formal ways in which the management and staff had got to know them or how they were involved in decisions about their care. However, people did say they felt staff knew who they were and their preferences. Staff showed in discussion with us that they cared about the people living in the home and would have liked to have more time to spend with them.

We observed staff speaking with people in a kindly manner, although we did note they did not always consider people's dignity. An example of this was when we were speaking with a person in the dining room. Whilst we were in conversation with the person, two staff came to support them to transfer into their wheelchair. One asked the other to prepare the person and put the handling belt on. When their colleague asked, "Isn't she talking?" the member of staff replied "No." The person was then transferred to their wheelchair and taken to the living room without being asked if this is what they wanted or if they had finished their conversation.

Prior to our inspection we had received some concerns, part of the concerns were about staff not supporting the person to change their clothing when needed and clothing not being looked after. We saw one person who had spilled their lunch on their clothing was not supported to change. We also saw some people's clothing screwed up in the bottom of their wardrobes. In addition, when we visited the laundry room, we saw workmen knocking down a wall without any of the clean clothing in the room being covered or removed prior to work starting. This demonstrated a lack of respect for people's belongings and dignity.

Some of the bedrooms we saw had been nicely personalised and looked well cared for. However other rooms were not clean, bedding was ill fitting and badly laundered and we saw dirty clothing left on the floor, incontinence aids stored where they could be seen and in one room, a used incontinence aid was visible in the waste bin. This demonstrated a lack of consideration of people's dignity.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw from staff training records that none of the staff had undertaken training in maintaining people's dignity, person centred care or principles of care and confidentiality.

None of the care records we looked at had been developed with a person centred approach.

We saw care records stored in an unlocked room with an open external door leading into the grounds. We also noted that care records were not kept individually. For example, different people's care plans were kept in one folder and other records such as bathing and weight records were made communally rather than individually. This meant that confidentiality was not maintained.

This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw during our visit people from the Jehovah's Witness religion were present in the home talking to people who lived there. We heard staff telling people who lived at the home that the people had "come to talk to them about Jesus." We asked staff if there were any Jehovah's Witness living in the home and were told us not. Staff told us people from other religious organisations also visited the home.

We noted, because there was only one lounge area and the visitors had been taken in there, people who lived at the home were not given the option of whether they wished to engage with them. Staff told us this was the case for all visitors from religious organisations.

We spoke with people about how often they saw visitors and whether there were any restrictions on when people could visit. All the people we spoke with said that they were not aware of any visiting restrictions. Several people mentioned the lack of space in the lounge and told us that visits tended to become communal as other people were in close proximity and could not help overhearing. All of the people we spoke with said they only received visits in the lounge.

Inadequate

Is the service responsive?

Our findings

None of the three people's care records we looked at in detail included any evidence of the person, or those acting on their behalf, having been involved in the development of the care plan.

None of the people we spoke with could tell us about their care plans or review of care. Two visiting relatives also said they were not aware of any care planning or review being carried out.

We asked people who lived at the home about opportunities to give feedback to the management of the home. Everybody we spoke with said that they were not aware of formal mechanisms for this. One person said "I don't think they would listen if we did."

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw little evidence of assessment of people's needs, preferences or abilities. Two of the care plans we looked at had not been reviewed or updated to reflect current needs. One person did not have any assessments or care plans in place other than the information provided to the home by the local authority. None of the care plans we saw had been developed in a person centred approach and we saw that staff had not received training in this area.

We saw from records that one person had recently been admitted to hospital. The person's care plan had not been updated to include details of their health problems. Another person who was ill at the time of our visit, did not have a care plan in place to inform staff of the person's needs or how they should be met.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we asked people if they received appropriate care, most felt that they did

Prior to our inspection we had received concerns that the manager of the home did not respond to people about their queries and concerns. One person, whose relative had been assaulted in the home, told us they had not received any contact from the manager despite trying to contact them on several occasions.

We saw two written complaints in the managers office. We asked the manager if we could see the complaints file along with detail of their responses to complaints received. The manager said they didn't have a complaints file and that there was no documented response to any complaints received.

None of the people we spoke with were able to tell us how they would make a complaint if they needed to. Some said they would speak to staff. One person told us of a complaint they had made about the thermostat on the radiator in their room not working properly and a blown light bulb in one of the fittings in their room. The person said that after two weeks this had still not been attended to.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke to people about their experience of services in the home. Problems with laundry were mentioned by more than one person. A visitor said of their relative's experience, "Several pairs of socks went missing. They replaced them with white ones – (The person) has never worn white socks in their life. They weren't a good fit either." One person who lived at the home said of their socks, "I don't bother sending them to the laundry now. I wash them myself and dry them on my radiator." Another visitor said, "We have never bought cheap clothes before but as they keep going missing we will have to start." One person said there was often a delay in getting laundry back, "I've know it take three days, and on one occasion it took six days to get my clean clothes, and then it wasn't all mine."

Prior to our inspection we had received concerns about the manager's dog being in the home. The complainant told us the dog was in the dining room which was very cramped and one person was saying to the dog, "Get away from me". Another person told us during our visit, "It jumped on my bed one morning." One person told us that the dog sometimes pinched food from them. The Commission had received concerns about this from a professional visitor to the home who had witnessed the dog taking food off the dining table. The manager told us the dog was trained not to take food and said, "but some of the residents gave him things and now sometimes this was a problem." We asked people what they thought of the presence of the dog. Most were ambivalent, some were positive and two said they did not really like it.

Inadequate

Is the service responsive?

We spoke with people who lived at the home about how they passed their time. Most people were positive about their experience of living in the home but were not able to tell us about a varied programme of activities that they could join in with.

People said: "It gets boring, there's not much apart from TV. There's not much planned for today." "Sometimes some of us go to a cafe but it's not very often. They only do it when they're trying to impress someone." "We might watch TV or have a quiz, If we get bored we have a sleep or start singing." "They put Breakfast at Tiffany's on one day, and then they put it on the next day as well." "Sometimes we have a singer - he's very good. We get some good entertainment."

We spoke with the activity co-ordinator who told us of different activities they arranged such as arts & crafts, singing, bingo, dominoes, quiz and daily exercise to music sessions. However we did not see any activities taking place. One person we spoke with said they came downstairs for the quiz and another person's care records showed they had joined in a sing song and bingo.

Inadequate

Is the service well-led?

Our findings

The person registered with Care Quality Commission (CQC) as the provider of the service was also registered as the manager. This person has been registered since August 2013.

We found the manager demonstrated little understanding of their responsibilities as registered person under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found there were no effective systems in place to monitor the quality of the service. We found the home was poorly organised.

We saw accident and incident reports had not been checked by the manager and the manager confirmed that they did not analyse accidents for potential trends or themes.

We did not see any evidence of effective monitoring of health and safety within the home. The manager told us people's views of the service were sought through questionnaires but when we asked to see them we were provided with blank questionnaires. The manager confirmed they had not sent any out.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found evidence of accidents and incidents which should have been notified to CQC but had not been.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

We also found evidence of safeguarding issues which had not been reported to the Local Authority.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In addition we were informed of accidents to staff for which referrals to RIDDOR (**Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) should have been made but had not.**

There was no evidence that people who used the service were involved in decisions about their care and there was no evidence of care reviews.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no processes in place for leadership within the home when the manager was not available. There were no senior care staff employed and nobody was identified as being in charge of care shifts.

We saw that staff responded to people's needs as they arose. However, this was not supported by any robust care planning or staff training.

Prior to this inspection we has received concerns about the service and the lack of response from the manager when people had requested contact or had made complaints.

We also received concerns from health and social care professionals about the managers' approach and attitude toward them. This situation could have an adverse affect on partnership working for the promotion of health and wellbeing of the people living at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Lack of consideration of people's dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Lack of any system or process in place for obtaining consent from people for the care and treatment received. Lack of awareness of legal duty to comply with the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected against the risks of unsafe or inappropriate care and treatment because there was a lack of proper information recorded by means of an accurate record in relation to their care and treatment. Records were not kept securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Failure to notify the Care Quality Commission of accidents and incidents to service users as specified in paragraph 2 of the above regulation.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Inadequate assessment, planning and delivery of care which does not meet the individual service user's needs and ensure the safety and welfare of the service users Lack of emergency procedures.

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Lack of effective processes to ensure that people are protected from risk of abuse by means of taking reasonable steps to identify the possibility of abuse before it arises and responding effectively to any allegations of abuse

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who used the service were at risk from living in a home where appropriate standards of cleanliness and hygiene were not being maintained.

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People using the service were not protected against the risk of inappropriate or unsafe care and treatment because the quality systems were not effective and risks were not being identified or managed.

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Lack of systems and processes in place to ensure that residents are protected from the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Lack of assurance that appropriate measures were taken to maintain the premises to ensure people's safety.

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

Regulated activity	Regulation
	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints Lack of effective systems in place for receiving, handling and responding to complaints.

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Lack of effective recruitment procedures in place to ensure the safe recruitment of staff

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Insufficient numbers of staff to safeguard the health safety and welfare of service users in the home

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Lack of suitable arrangements in place to ensure that staff employed at the home are adequately supported in relation to their responsibilities to enable them to deliver effective care to service users safely and to an appropriate standard

The enforcement action we took:
Notice of Proposal to cancel the registration to be issued