Countrywide Care Homes Limited

Howgate House

Inspection report

Howgate
Idle
Bradford
West Yorkshire
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09 November 2016
10 November 2016
23 November 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014. The inspection was unannounced. At the last inspection in January 2015 the home met all the national standards that we looked at.

Howgate House provides accommodation with nursing or personal care for up to 63 people over three floors. All the rooms are single rooms although there is one room which can be shared by two people. There is a lounge and dining area on two floors and disabled toilet and bathing facilities. The building has access for people with disabilities and there is a passenger lift to all floors.

We saw medicines were stored appropriately and saw people were not rushed when being supported with taking their medicines. However the management of medicines were not always recorded properly and medicines to be taken as and when required [PRN] did not have the documentation near the medicines for staff to refer to.

Care plans were reviewed regularly however any changes required were not altered in the original care records for people. We looked at care records for eight people and found the most up to date information had not been captured. This increased the risk of people receiving unsafe or inappropriate care and treatment.

Staff, people and relatives all told us they thought there was not always enough staff on duty to support people effectively. We made observations during our inspection that illustrated staff were task orientated. This meant people were sometimes left waiting when they needed support.

Risks to people had been assessed and in most cases staff had taken action to reduce these risks. However risk assessments were reviewed regularly, but the updated information was not always recorded on the original assessment. Inaccurate recording increased risks to people with reduced nutritional intake.

Equipment was not always fir for purpose. Call bells were not always left within reach for people. This left some people unable to call for help when they needed it.

Staff did not always know the current needs of the people they supported. Staff did not always share information effectively. Confidential information was sometimes left out, and staff were talking openly between each other in a communal area about people.

People were supported to stay healthy and to obtain medical treatment if they needed it.

The registered manager and staff acted in accordance with the requirements of the Mental Capacity Act

2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's capacity to make decisions had been assessed and meetings had been held to ensure that decisions taken about people who lacked capacity were made in their best interests. Applications for DoLS authorisations had been submitted where restrictions were imposed upon people to keep them safe.

People sometimes enjoyed the food provided and could have alternatives to the menu if they wished. However the menu did not always indicate the correct options for that day. People were not always given the support and encouragement they required to eat sufficient portions. We saw drinks were available if people asked for them but they were not left out for people to help themselves.

Staff were usually kind and sensitive to people's needs. People had positive relationships with the staff who supported them. Relatives had mixed reviews that staff provided compassionate care and were professional and caring.

Staff had access to the training, supervision and support they needed to do their jobs. New staff completed an induction and then a shadow period. Staff we spoke with told us the training was effective in supporting them to complete their roles. However, our observations showed training had not ensured staff followed best practice at all times which put people at risk of unsafe care and treatment.

The provider made appropriate checks on staff before they started work, which helped to ensure only suitable applicants were employed. Staff understood safeguarding procedures and were aware of the provider's whistle-blowing policy.

The atmosphere in the service was calm and relaxed and staff spoke to people in a respectful and friendly manner. Staff told us they understood the importance of maintaining confidentiality and of respecting people's privacy and dignity. However were saw examples when people's dignity was not always respected. Relatives told us they were made welcome when they visited.

We saw no meaningful activities taking place during the three days of inspection. People told us they were bored and had nothing to do. The activities board was blank. People were sat in lounge areas with no stimulation for over two hours.

The provider had a complaints procedure, which was given to people and their families when they moved in. Any complaints received had been appropriately investigated and responded to. Regular residents and relatives meetings had taken place to provide opportunities for people to give their views.

People and their relatives told us their feedback was encouraged and listened to. They said the service was well run and that the management team was open and approachable. Staff told us the registered manager promoted a positive culture at work.

The provider had an ineffective quality assurance systems in place that had not identified the areas of concern we raised on the days of inspection. Records relating to people's care were not always accurate, or up to date.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

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.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Risks Assessments did not always reflect people's current areas of risk.

Equipment was not always maintained and used safely.

The administration of medicines were not always recorded correctly and documentation was not always stored with medicines.

Staffing levels at times were stretched and staff became task orientated.

Is the service effective?

Inadequate

The service was not effective.

People were sometimes left with food but were unable to support themselves. Recordings of nutritional intake was incorrect. Drinks were not readily available for people.

Relatives told us communication between staff was not always effective. Staff were not always respectful to people and spoke about them around others.

The service had acquired the correct authorisations to deprive people of their liberty lawfully and in the least restrictive way.

People were supported to access health professionals if they required additional help.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw people were not always involved in the planning of their care.

People's personal information was sometimes left out in communal areas without staff supervision.

People's dignity was not always respected.

Is the service responsive?

Inadequate

The service was not responsive.

Care records did not always contain the most up to date information about people. This meant the provider could not demonstrate they were safely meeting people's current assessed needs.

There were no activities available to people during the days of inspection. People told us they were bored.

Complaints were documented and actioned to improve services.

Is the service well-led?

Inadequate

The service was not well-led.

Audits had not always identified areas of concern or improvement.

Areas of concerns we received prior to inspection had been shared with the registered manager had not been dealt with.

People told us the registered manager had a presence in the service and would act on concerns people had.

People and their relatives had opportunity to voice their opinions and views.

Howgate House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014. The inspection was unannounced. At the last inspection in January 2015 the home met all the national standards we looked at.

We visited the home on 09, 10 and 23 November 2016.

The inspection team consisted of six inspectors and one expert by experience. An expert by experience is someone who had personal experience with this type of service. The expert by experience had experience with people in the early stages of dementia and older people who use regulated services.

Before the inspection took place, we received information of concern. During the inspection, we spoke with 20 people who used the service and six relatives.

We spent time observing care and speaking with the operations manager, registered manager, two nurses and six care assistants. We looked at eight people's care records, six staff files as well as documentation relating to the management of the service such as training records and policies and procedures. We also reviewed information we had received about the service such as statutory notifications. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had completed and returned this form to us.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the service. Comments included: "I have no problem with safety, I feel safe and comfortable "and, "Yes comfortable, they don't harm me, they look after me." One relative told us, "I think my relative is safe."

However, some people told us they there were not always enough staff to meet their needs and staff were sometimes delayed when they called for them. We asked people if staff responded promptly when they pressed the call alarm and no one complained about having to wait an unacceptable amount of time. However, one person said, "They come quickly if I press the alarm but sometimes it is left out of my reach and I just have to wait for someone to appear." Another person said, "I press the buzzer, they come after ten minutes. " On the days of inspection we observed some people did not have the call bell system within reach. This confirmed to us the practice of leaving people without call bells within reach was not an isolated occurrence.

The staff we spoke with had differing views on the staffing levels at the home. For example, while some staff felt there were always sufficient staff on duty other staff told us they did at times feel under pressure at peak periods of the day including mealtimes and there were not always sufficient staff on duty. They told us the number of people who now required two staff to assist them had increased significantly and they were finding it difficult to manage their workload. Some staff told us morale was low because staffing was an issue and people were working long hours. One staff member told us, "Morale is down because people are run off their feet." They added, "We're always having to come in on our days off. It's not right. These are people's lives we're talking about. You shouldn't have to be running around like crazy. We'll do the best we can but can be here, there and everywhere." One relative we spoke with told us, "I ask the carers to change [person's name] sometimes as it has not been done."

We observed staffing levels during our inspection and saw staff were focused on tasks during busier times. For example, people were waiting in the lounge and dining room for breakfast when we arrived at 8am and food service began after 9am. Staff told us they had been deployed on care duties elsewhere during this time and were short staffed since one staff member had been sent to hospital with a person living at the service. One member of staff said there was some impact on people's wait times for support if staff were supporting a person who required the support of two staff at the same time. Another member of staff said they were concerned when the service was short-staffed and there wasn't a staff presence in the lounge area. We saw people sitting for long periods of time with no stimulation or contact with staff. We observed through one lunch time, one person was clearly struggling to cut their pie. Support was not offered until almost everyone else had eaten. They used a spoon to try and eat their food but they only ate the food that dropped onto the table, their clothing protector and lap. We spoke with a relative who told us their family member was settled, however they also commented, "The feeling's there but isn't followed through." They explained this further by telling us they thought the care was task orientated rather than person centred and although staff meant well, there were not enough to provide effective care.

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

2014.

Other risks to people's personal safety had been assessed and people had plans in place to manage the risks. We saw risk assessments were in place for each person that covered areas such as infection control, moving and handling, bed rails, nutrition, falls and skin integrity. However, we found the majority of risk assessments for one person had been initially completed following their admission in May 2014 and just been evaluated on a monthly basis. Although the staff on duty told us they felt the risk assessments were still appropriate to the person's needs we found they lacked detail and required updating. We found one person's risk assessment and care plan had been reviewed rather than updated and this meant staff had to work through seven pages of information to get to the relevant information. For example, the moving and handling risk assessment made no reference about how the person preferred to be transferred or that staff should always seek consent and reassure them before assisting to transfer. We therefore could not find the relevant information to meet the person's needs.

We walked around the premises. The upstairs area was clean and well maintained, although some areas at the back of the dining room required some updating with plasterwork needing repair. We saw safety mechanisms such as window restrictors and radiator covers were in place. However when we tested the hot water temperature in three upstairs bathroom sinks we found this quickly became too hot to comfortably keep our hands under the water. This meant people may have been at increased risks of scalds. On the day of inspection we noted three people's bedrooms had a strong odour. For example we spoke with one person in their bedroom whose room had an odour although their room looked clean and tidy. We informed the registered manager of our findings and they immediately asked a member of the housekeeping staff to clean the room and try and locate the cause. We returned to the same room in the afternoon of the inspection and although the room had been thoroughly cleaned the odour remained. We again informed the registered manager who confirmed they would look into the problem.

We looked at the specialist pressure relieving cushions located in the upstairs seating area. We saw two cushions that used air flow to reduce risks of pressure ulcers forming were in use. However, one of these cushions had one of the tubes disconnected for the whole of the morning. This meant the person was not receiving the correct pressure relief for the entire morning, although it stated on their record chart, 'pressure relief given.' We pointed this out to the registered manager who replaced the tubing. The second cushion we saw in the lounge area had a very noisy compressor unit. We checked the unit and saw this had not had any electrical safety testing recorded. The blower box was stained and the material covering the cabling from the box to the cushion was marked and dirty. We saw a length of exposed wiring connecting the rear of the blower unit to the electric socket in the wall. We concluded this was not safe and brought it to the attention of the registered manager. We saw infection control issues with a number of other static pressure relieving cushions, one of which had a delaminated surface and another with staining on the underneath. We concluded the service had not carried out appropriate cleaning, checks and maintenance of this type of equipment to reduce risks to people using the service.

Some people required hoisting to assist them transferring. Most of this was carried out correctly. However, we observed staff assisting one person to transfer from an armchair to a wheelchair using a 'turn assist' aid. The person's feet were not positioned correctly on the aid and we saw staff drag the person back onto the wheelchair, whose brakes had not been applied. This meant the wheelchair moved backwards increasing the risk of injury to both staff and the person.

Medicines were not always administered in a safe way. We observed staff administering medicines; staff supported people to take their medicines in line with their prescription. People had individual protocols for medicines that were not given as a regular dose but to be taken when required (PRN). Protocols gave staff

detailed guidance about why the person might need PRN medicine and when they could take it. However we found the protocols were not stored with people's medicines or the Medicine administration records (MAR). We mentioned this to the registered manager and clinical lead nurse who agreed to copy or move the documents to be more accessible for staff.

Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why. There was not always accurate recording of the administration of medicines. We observed one member of staff administering medicines on the day of inspection. We saw they had signed the MAR to indicate the medicines had been administered prior to taking them to the person. We asked why they did this and they told us they used this method as a final check but agreed it was not good practice.

These examples of shortfalls in the management of pressure area care, moving and handling and the administration of medicines meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people refused their medicines but were assessed as lacking mental capacity to make decisions around their health needs, staff took appropriate action. Where it was found to be in the person's best interest, people received their medicines covertly which meant their medicine could be lawfully hidden in food or drink.

We saw medicines were stored safely. Temperature checks of the storage area and those medicines to be kept refrigerated were monitored and recorded on a daily basis. Controlled drugs were stored and recorded in line with the provider's policy. Only nurses and management staff held keys to the medicines room.

The staff we spoke with told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local authority Adult Protection Unit and the Care Quality Commission (CQC) if they had any concerns. Staff told us they thought people were generally safe.

We reviewed six staff files and saw safe recruitment procedures had been followed. This included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

We observed in the lounge area during the inspection. We saw one person was given a nutritional supplement after breakfast; however the person only drank a small amount of this. We observed the food and fluid offered to the person during the course of the day and saw they did not eat any of their lunch or drink more than a few sips of fluid during this period. We spoke with a staff member who told us they were concerned about this person since they had also noted this. However, when we looked at the food and fluid charts for that person later, we saw it documented they had consumed all their lunch and drunk 400mls of tea. This was not correct. We also observed one member of staff filling in these charts in bulk rather than for individuals after observing their correct intake. We concluded staff were not accurately recording the correct information on these charts. This meant people were at risk of not receiving the nutrition and fluids they required for their daily intake and this might not be identified when the documents were reviewed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Further observations in the lounge and dining area concluded people were waiting for over an hour for breakfast in the morning. One person asked, "Can we have some breakfast? We're all hungry and we'd like some breakfast." However, staff were not in the lounge or dining area to respond to this. We saw drinks were not available to people unless they asked for them.

Menu cards were placed on the tables and a daily menu board was written on a board in the dining room. However when we looked at the menu cards on the tables we saw these were not for the correct day which was confusing people when they were reading what food to expect that day.

People told us, "The food's all right," and another person told us they were given good food to help control their diabetes. We heard staff asking people if they wanted more food to eat once they had finished their food and portion sizes looked generous. A further person told us, "Bad quality- If I don't like it I leave it." Other comments included, "Bad food, If you tell them it is like talking to the TV. I like stews but don't get them. Look I have food in my room, never mind," and, "The food is not consistent, what you pay for you don't get. I have a particular diet due to my condition, a high protein diet. I have to insist that I need scramble eggs for breakfast, sometimes they give me the wrong food and I send this back. They don't replace the meal so I then eat the food I have in my room." This showed us people did not receive the food they asked for and sometimes left the food because they did not enjoy it. We concluded people's nutritional care and support was not being adequately planned and met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with relatives who were concerned about the lack of communication between staff shifts. One family member told us they bought food in for their relative daily and told staff on shift they had done so. They said they often found this food untouched the next day and when asked, staff told them they weren't aware and said, "It's not my shift." We observed staff speaking about people in a general way within earshot of others. For example we heard one staff member say, "There's this lot in here to sit down. You do him and

I'll do [person's name]", "I'll go do [person's name], who are you doing next," and "Who's next? I've done hers. Five is a soft." We saw further instances of staff talking over people and heard staff at breakfast time saying to each other, "There's just trays to do," and one kitchen staff member loudly asked staff at lunchtime, "Have they all been fed?" This showed us the communication between staff was not always personalised or effective. We raised this with the registered manager who agreed further training and a reminder of staff's duties was required.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us eight people who used the service had standard authorisations in place and a further nine referrals had been made but not yet authorised. We saw evidence some referrals had been made some time ago and the registered manager had made several attempts to contact the supervisory body for an update on the current situation.

We looked at the conditions made on two of the standard authorisations and found they were being met.

However, we found the care plan evaluation report for one person dated 29 September 2016 stated '[Name of person] was unable to make decisions regarding their health and welfare. They have a DoLS in place.' When we checked this with the registered manager they told us although the person had previously had a DoLS in place and a new referral had been made for a standard authorisation it had not yet been granted by the supervisory body. The registered manager told us this was a genuine mistake on the part of the staff member completing the care plan evaluation and dealt with the matter immediately.

Both the registered manager and staff members we spoke with had a good understanding of MCA and DoLS including their roles and responsibilities.

We saw some evidence of consent and people's preferences being sought during the inspection. For instance, we heard one staff member who was administering medicines on the morning of the inspection ask someone about using their inhaler saying, "Do you want to do it or do you want me to do it?" Another person was approached by a member of staff about using protective clothing during mealtimes. They said, "[Person's name], would you like one of these on for your breakfast?" However we saw a number of instances where people were not asked for their consent. For example we observed staff put food on plates for people and added gravy with no consultation about quantities or component parts of the meal.

We looked at the training matrix and saw the provider's mandatory training had been completed by staff within the recommended time frames for each training course or was planned in advance. We saw training was provided in a number of different ways including E-learning, in-house training and staff attending

external training courses. We saw the service had a system to highlight when staff needed to update their training. Staff told us they received good training to equip them for their role and there were plenty of training opportunities.

The registered manager told us individual staff training and personal development needs were identified during their formal one to one supervision meetings and their annual appraisal. Staff spoke positively about the training provided by the organisation and confirmed they received regular updates in a range of the provider's mandatory topics. People told us they thought staff had been trained well. Comments included, "They are all up to the standard but some very good, some good", "I have been here for 15 years, yes they know what they are doing, "and, "Most of the time they know what they are doing." We did however identify issues during the inspection that led us to question whether all staff had the knowledge they needed to support people safely. This included poor moving and handling practice, a failure to always use positive language when referring to people who used the service, poor practice in recording and the administration of medicines.

We saw in people's care files that they had access to a range of health care professionals including GPs, district nurses, dieticians, speech and language therapists, dentists, opticians and chiropodists. On the day of inspection we observed a person in lounge complained of feeling unwell. A member of staff said they would 'see what they could do', offered pain killers and suggested contacting the doctor giving reassurance. With the person's permission, this member of staff then contacted the doctor for a home visit.

Requires Improvement

Is the service caring?

Our findings

During the inspection we viewed different areas of the home. When we arrived in the upstairs lounge, we saw a variety of charts had been left unsupervised on the coffee tables. These documents contained information on named people living at the service, including visual observations, acute care record, positional change chart, fluid balance chart, nutritional chart and two hourly cares chart. Some of these charts contained very personal details about people's personal care. The charts remained on the tables until removed at 11:00am and people were sat in the lounge during this period. This meant people's confidentiality and right to privacy had not been upheld by the service.

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

During the inspection we heard some caring interventions. For instance, during the course of the morning, several people had their hair done by the hairdresser and staff commented how lovely they looked. Another person was becoming distressed when hoisted into an armchair in the lounge. A staff member was constantly reassuring them, saying, "its okay, you're safe, you're all right," and talking them through what was happening. We heard a member of staff asking people if they wanted a biscuit with their cup of tea in the afternoon, taking care to pick out the biscuits they liked, saying, "[Person's name]; there's some of your favourites." We saw staff, when they were present, generally responded to people's needs.

We saw another person who had limited dexterity was hoisted into an armchair and a member of staff folded their cardigan, placing it over the back of the armchair, saying, "Your jacket is behind you." The position of the cardigan would have been impossible for the person to reach if they wanted it.

Staff we spoke with knew people well and were able to tell us about their likes, dislikes and care needs. A member of staff told us, "You get to know every way about every person. I know these residents more than I know myself." For example, they told us about one person they felt wasn't very well and they had passed this information on to the nursing staff.

We observed staff knocking at people's doors before entering their bedrooms. A staff member told us, "A person is entitled to their privacy."

We spoke to a relative who told us, "[Person's name] is settled." They also said, "Staff need to move with the times," and commented they didn't feel the service did enough to promote people's independence. However, another visitor we spoke with praised staff and told us, "They're really good to them [people who used the service]."

We observed over lunchtime and saw one person was given their meal in the lounge area, with the plate put on an over bed table. However, the table was not placed close enough for the person to comfortably reach their food. This meant they spilled food on themselves. No protection for their clothing was offered until a staff member brought the person's dessert and also moved the table closer. We saw this person's care plan

stated, 'Staff need to ensure that everything [person's name] needs is within easy reach at all times.' We observed another person who struggled to eat their lunch and was only able to eat the bits they spilled onto the table. As this person took a significant period of time to eat their meal, they were not offered a dessert. This showed us people were not always supported to maintain their dignity with support or equipment.

Some people were brought to the dining table area in their wheelchairs and not transferred to dining chairs. One person we saw was wheeled in front of the television and left, rather than transferring them to a spare armchair. People were not given the option to sit in the dining area in the same chairs as their friends to promote their independence and respect their dignity.

We saw some people wearing stained or un-ironed clothing. People's clothing did not look well cared for, with some clothing ill-fitting or containing holes and some people's hair looked unkempt. For instance, we observed one person we were speaking with early on one day of inspection was wearing a visibly stained top. When we saw them later in the afternoon and saw they were wearing the same stained top covered with a cardigan. We saw another person wearing a cardigan with a large hole in the shoulder and further person wearing stained clothes which looked un-ironed.

Prior to our inspection we received information of concern suggesting people were not supported appropriately on an evening and could be found in bed fully dressed. On the first evening of our inspection we found this was the case. We saw two people had retired to their bedrooms to go to sleep but had not been supported to remove their clothes they had been wearing during the day. This was reported to the registered manager who told us they would get up and down in the night and were able to dress and undress themselves. However staff did not encourage people to change into night wear when they wanted to go to bed and people's choice about wearing clothes when they go to bed was not recorded in their care plan.

Inadequate

Is the service responsive?

Our findings

We looked at seven people's care records. We found records were not person centred and did not always provide staff with accurate up to date information and at times contained generic phrases, such as 'All staff to be aware of abilities and limitations.' For example, we saw the initial care records and risk assessments for one person with complex needs had been completed following their admission in May 2014 and had been evaluated monthly since that time. We saw their care record for communication stated '[Name of person] was able to give yes or no answers to questions but will not engage in conversation.' However, we spoke at length with this person and they told us about their past life and how they would like the opportunity to go out and about more. This demonstrated to us that their care plan was not reflective of their current communication needs.

We looked at another person's care records and found conflicting information. For instance, one part of their care record stated they were not to be left at the dining room table sitting in their wheelchair. We saw the person earlier in the day in their wheel chair at the dining table. The same care record was seen to have been updated with 'no changes' recorded. However, in another section of the person's records, it suggested the wheelchair services had said the person could remain in the wheelchair for short periods of time. These inconsistencies meant the provider could not demonstrate they were meeting the person's current assessed needs.
We reviewed the weight charts for one person and saw conflicting information about if the person needed weighing weekly or monthly. When we spoke to the registered manager about this they were unsure which was correct. We also saw this person's care records stated they should not be left in the dining room to eat unsupervised due to a choking risk. However, we saw them eating unsupervised whilst staff were attending to other people in the lounge area. This showed us staff were unclear about information to follow in people's care records as directions were not always followed.

This meant risks to people were not being appropriately managed. This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence that some people were not routinely involved in their care plan reviews. We asked people about reviews and they did not know what they were.
In addition, we saw the nutritional care plan for one person initially completed in May 2014 showed they had diabetes and required assistance to prepare/cut up food. However, the care plan did not indicate what assistance the person required or their dietary preferences. The care plan had been evaluated monthly since May 2014. We saw the evaluation report for September 2016 stated 'Diabetic and overweight. Encouraged to reduce junk food intake. Has gained 0.9Kg this month.' However, we found the nutritional care plan had not been updated to reflect this. We discussed our findings with the registered manager who acknowledged the care records had not been updated as required and dealt with the matter immediately.

During our inspection we observed care and support in the upstairs lounge area. We observed one person had a visibly runny nose with a large amount of thick nasal mucus at 8am. During the course of the morning, this person had wiped their nose with their hands several times and by 12:00pm we could see the fluid had

run down into the person's mouth, chin and onto their top. The person had a paper serviette in their lap but no-one had attended to them in this time. This person also had a productive cough but had not been provided with appropriate support and tissues.

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

We saw a lack of activities or meaningful stimulation in the service throughout the three days of our inspection. We saw the television was not always put on while people were in the lounge areas and sometimes we saw the sound muted. For example on one occasion people were sat in one lounge area from 8am and a member of staff noticed there was no sound on the TV at 10.30am and turned the volume on, however this was then muted at lunchtime. No music was played and staff did not appear to have the time to sit with people. This meant people were sitting in silence with no stimulation whatsoever. Staff we spoke with told us the activities co-ordinator was on holiday and when this happened, no activities were organised. A few people we observed told us that there was nothing to do and they were bored. Comments included, "We used to go out all the time," "I go home- don't know of activities in the home," I watch TV all day, like everyone else," and "I sit and watch TV or gaze out of the window- that's all I do all day." We observed that one person spent all day wondering up and down the corridor and sitting in the hallway. This showed us activities did not occur when the co-ordinator was off and people were not stimulated.

These examples amount to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some people were asked what they would prefer to eat for their meals. For instance, one person was asked if they wanted a cooked breakfast or cereal and toast. Some people preferred to stay in their rooms and their wishes were respected. For instance, one person's relative told us their relative did not like sitting in the lounge area and preferred their own company. We saw this person went to the lounge to eat their meal and stayed in their room otherwise.

The provider had a written complaints procedure, which detailed how complaints would be managed and explained how people could escalate their complaints if they were not satisfied with the provider's response. Information about how to complain was provided to people and their relatives when they moved into the service and was published on the wall of the service. We checked the complaints record and found that concerns raised had been appropriately investigated and responded to. Complaints were monitored and analysed for trends and summarised annually.

Inadequate

Is the service well-led?

Our findings

The management team used systems and audits to monitor and improve the quality of the service. Audits were carried out which checked key areas of service delivery, such as health and safety, care records, medicines management and infection control. A report of each quality check was produced and the actions taken where areas had been identified for improvement. However audits had not always identified the areas of concern we raised on the days of inspection. For example checks of people's care records had not identified information was old and did not meet the current needs of the people who used the service. Other plans of care were updated monthly, however as the original plan was not amended this led to one person's plan for support with their mobility was eight pages long with the relevant information difficult to find . This was not discovered in the audits.

The CQC was made aware of concerns prior to this inspection and these were shared with the registered manager. One of the areas of concern was some people's rooms were malodourous. During all three days of inspection we found rooms had offensive smells, and although some action had been taken to clean the room, the source of the smell was still present. We found daily recording charts had been filled out incorrectly. For example recordings of 200ml fluid intake was recorded when the cups people used to drink contained 150mls only. This had not been identified or addressed by the service. We found call bells were not always within reach of people and were not present in communal areas. People told us they were not always left with them. This showed us environmental audits had not identified existing concerns with call bells. One quarterly audit to be undertaken by a senior manager from the provider had not always been completed in full and some gaps had been left. This showed us current audit tools had not highlighted areas of concern leaving people with continued risk of unsafe and undignified care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the registered manager held regular health and safety meetings with the heads of each department working within the home. This included representatives from the catering, maintenance and housekeeping staff. The registered manager told us each head of department provided a report which included any new risks and staff training and performance information. They also told us the meeting was used to discuss any changes in legislation and to discuss any themes and trends identified through the quality assurance monitoring system in place.

We also saw general staff meetings had been held on a regular basis which enabled staff to have their views and opinions of the service provided and to keep them up to date with any changes in policies and procedures. In addition, we looked at the minutes of the last resident/relative meeting held on the 24 October 2016 which was attended by seven people living at the home and three relatives. We saw agenda topics covered topics including concerns and complaints, catering and people's views of the care and facilities provided.

The registered manager told us they delegated some key roles in the home to specific staff and we saw the

service had an infection control lead, dementia lead and dignity champions. We concluded from the concerns we identified at this inspection that these roles had not been effective in securing improved practice in these areas. The registered manager also told us the organisation sent out an annual survey via an external company to people who lived at the home and their relatives. They told us the closing date for questionnaires to be returned for the 2016 survey had only recently passed and the information received had not yet been collated. We therefore asked the registered manager to forward the results of the survey once available. The provider shared the results with us after the inspection that showed people were generally satisfied with their care.

Relatives told us the service was well run and that they had confidence in the management team. They said the registered manager provided good leadership for the service and were open and approachable. One relative told us, "[Registered manager] are always around and we can ask to see them if we wish." On the day of inspection we observed a relative approach the registered manager and raise an initial concern. The registered manager supported the family member to resolve the issue before it became a problem.

Staff we spoke with told us they felt well supported and confident in the way the registered manager ran the service. Staff said they could approach the registered manager or higher management with any concerns and felt they would deal with concerns appropriately. They said they saw the quality manager from time to time. Staff told us managers' completed a spot check of their work.

Staff also told us morale was 'up and down', some days better than others, depending on staffing levels and how many shifts they had worked. Staff all reported teamwork as a strength. Care staff spoken with said the registered manager helped out if they were busy and supported them day to day. Care staff said they were not aware of any unacceptable practice / bullying in the service. However the nurse in charge told us they were aware of some staff's 'bad attitude' and had discussed this with the registered manager. The registered manager told us they had previously been aware of staff's attitude and had addressed this.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care records did not identify their current needs. People did not receive the food or drinks they wanted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff spoke on top of other people and supported people while talking to others. Relatives told us information was not passed on from one shift to another.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risk of pressure sores. PRN protocols were not stored with medicines or MAR's. Staff did not follow safe manual handling techniques.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People's daily charts were not completed correctly. Concerns were not identified through quality assurance processes.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

Staffing levels were not sufficient and did not always meet people's needs.