Care Quality Commission

Bondcare Shaftesbury Limited

Redworth location

Inspection report

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Shildon
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Ratings

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

Overall summary

This inspection took place on 27 and 28 October and 5 November 2014 and was unannounced.

Redworth provides care and accommodation for up to 57 people. The home is divided into four separate units. On the first floor there are three units, the first for up to 22 people with dementia care needs (there were 18 people accommodated there during our inspection), the second for up to six people who have a learning disability (there was one person living there at the time of our inspection) and the third for up to four people with intermediate care needs, whereby they were accommodated whilst they recovered following a period of illness or injury (there were two people in receipt of intermediate care during our visit). On the ground floor there is one unit for 25 people with nursing or 'residential' needs some of whom also have dementia (there were sixteen people accommodated there during our inspection).

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how a service is run.

We found Redworth to be inadequate in all areas we inspected. We looked at guidance for providers in dementia care including the following:-

- The National Institute for Care Excellence (NICE) 'Dementia Supporting people with dementia and their carer's in health and social care 2006;
- Alzheimer's Society Fact Sheet 2013. Staying Involved and Active
- The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance' and
- The NICE guidelines 'Pressure ulcers: prevention and management of pressure ulcers 2014'

The provider had failed to take account of this guidance.

We found people had access to other health care professionals. However, guidance from them was not always acted upon. For example; in one instance another health and social care professional had provided the care workers with information about a person's care needs and associated risks. There was no evidence either from observations made by us of care practice or from the care records examined that the recommendations made had been carried out.

We found the home was not clean. There was a strong unpleasant odour throughout the first floor of the home. We found a number of mattresses and chairs were dirty and stained placing people at risk of cross infection. The environment had not been adapted to meet the needs of people with dementia to help promote their independence and well-being.

We examined the medication records and found on one occasion one person had been given the wrong amount of their prescribed medication. We also found that other people had not been given their prescribed medication because there was none available in the home. This placed services users at serious risk of harm.

The person in charge could not provide us with evidence to demonstrate that all safeguarding incidents had been reported to the Local Safeguarding Authority or to the Commission.

Risks to people's care and welfare were not managed safely. For example, people at high risk of malnutrition were at risk because food and fluid charts were not being used properly to make sure people were eating and drinking enough. The care plans we looked at did not reflect how to manage peoples' diverse needs, for example, how to support people who may, as a result of their dementia, become agitated.

We found there were enough staff on duty to meet people's needs. However, the provider could not demonstrate that all staff had been provided with specialist training to meet the needs of the people in their care.

People living on the ground floor of the home told us they were treated with dignity and encouraged to be independent. However, for people with more advanced dementia care needs, this was not case. For example, for two days we heard a service user crying out from their room and did not observe staff at any time to attend to this person's obvious distress. Although there were activities taking place for people on the ground floor of the home this was not the case for people with more advanced dementia care needs living on the first floor of the home. We saw no activities taking place over the two days of our inspection and there was very little on the first floor for people to do. Our observations of care practices, particularly on the first floor of the home, and the care plans we looked at, demonstrated people's needs were not catered for in an individualised way.

We discussed the quality assurance systems in place with the regional manager and deputy manager. We were told regular audits were carried out of the care home which included the number of accidents and safeguarding incidents each month. However, there was no evidence of any action being taken to prevent these from happening again. We saw the audits carried out had failed to identify poor standards of care within the care home.

We found a number of breaches of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we took 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.

There were enough staff on duty and appropriate checks were in place to make sure new staff were appropriately recruited.

Risk management procedures were not in place to make sure people were kept safe form the risk of harm. The person in charge could not provide us with evidence to demonstrate that all safeguarding incidents had been reported to the Local Safeguarding Authority or to the Commission.

The standard of cleanliness and hygiene was inadequate. We found medicines were not managed safely and the building was not well maintained.

Is the service effective?

Inadequate

The service was not effective.

There was no evidence that best practice guidelines were being put into practise. Although people had access to other health care professionals, guidance from them was not always acted upon.

Some staff did not have up-to date training about the needs of the people in their care and the person in charge was not able to tell us what training each member of staff had had.

People were not protected from the risks of inadequate nutrition. The environment was not effective as it had not been adapted to meet the needs of people with dementia

Is the service caring?

Inadequate

The service was not caring.

Although people living on the ground floor were treated with dignity and encouraged to be independent. This was not the case for people with more advanced dementia care needs.

We saw no activities taking place over the two days of our inspection for people with advanced dementia living on the first floor of the home.

People we spoke with told us they had not been involved in their care plan.

Is the service responsive?

Inadequate

The service was not responsive.

Observations we made of care practices, particularly on the first floor of the home, and the care plans we looked at, demonstrated people's needs were not catered for in an individualised way.

There was a complaints procedure and people told us they would complain to staff if they had any concerns.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The home had a registered manager in post, however, they were not present for the inspection.

The regional manager carried out audits of the care home which included the number of accidents and safeguarding incidents each month. However, there was no evidence of any action being taken to prevent these from happening again.

The quality assurance audits carried out by the regional manager had failed to identify poor standards of care within the care home.

Redworth location

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27, 28 October 2014 and 5 November 2014 and was unannounced.

The inspection team consisted of two Adult Social Care inspectors, 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 whose specialism was in the area of older people) and a specialist advisor (who specialised in mental health).

Before this inspection we reviewed notifications that we had received from the service. We also reviewed information from people who had contacted us about the service since the last inspection, for example, people who wished to compliment or had concerns about the service.

The methods that were used during this inspection included talking with eight service users, nine visitors, unstructured interviews with the deputy manager, regional manager, nurse in charge and four care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spent seven hours observing care practices in all areas of the home. We examined six service users care records, seven people's medication records, four staff recruitment and training files, three staff rotas, the most recent infection control audit, and four 'Regional Managers Monthly Reviews.'

Before the inspection we obtained information from an Operations Manager of Durham County Council learning disability team, a Senior Commissioning Officer of Durham County Council, a Safeguarding Practice Officer and Safeguarding Lead Officer of Durham County Council, three social workers, two 'Assistant Team Managers', a lead Infection Control Nurse and a Community Nurse.

For this inspection, the provider was not asked 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.

Inadequate

Is the service safe?

Our findings

During our inspection we spent time on the first floor of the home and carried out an inspection of seven service users' bedrooms and en-suite facilities. In three of these bedrooms and en-suite facilities we found prescribed creams and ointments which if ingested or used incorrectly could cause potential harm to service users. For example, in one en-suite toilet, on an easily accessible shelf, we found Cavilon cream and two Proshield foam skin cleaners (prescribed for cleansing intact or injured skin in people with severe or chronic diarrhoea or incontinence, for the removal of urine and faeces, dried blood, postoperative antiseptic solutions and other hard-to-remove debris. With a contraindication 'for external use only and avoid contact with eyes'). In the en-suite toilet of another bedroom we found an Aqueous cream, foam spray skin cleaner and Diprobase creams. In a third bedroom we found Calicipotriol ointment (a cream used for the treatment of psoriasis which can cause skin irritation and should not be used on a person's face) lying on the chest of drawers and in the en-suite toilet facility Hydromol ointment (a moisturising ointment with the instruction 'for external use only').

Over the course of the two days of the inspection we observed a service user walk along the corridors and enter other service user's rooms without the supervision of staff. There were no safeguards in place to minimise the risks of this service user accidentally or deliberately ingesting potentially dangerous creams and medications designated only to be used externally. We advised the deputy manager in charge that prescribed creams were accessible to service users and may place them at risk of harm. We asked the regional manager and deputy manager if risk assessments had been carried out in relation to the prescribed creams being left accessible to people with advanced dementia care needs. We were told that no risk assessments had been carried out in relation to the storage of prescribed creams and that it was the policy of the home for prescribed creams and ointments to be kept in a locked facility which was available in each person's bedroom. This showed service users were at serious risk of harm because prescribed creams and ointments were not securely stored and people with advanced dementia could have accidentally or deliberately ingested them.

During our inspection we identified that serious safeguarding incidents had not been reported to the local safeguarding authority or to the Commission. We examined the accident and incident file. We saw that an accident had been recorded on 22 September 2014 where a service user had been 'pushed over by a fellow resident'. We saw another incident recorded in the accident and incident file which stated that on the 14 July 2014 a service user was found on the floor with a another service user standing over them. On the 31 July 2014 we saw a third incident recording where a service user was 'pushed over by another resident'. We asked the regional manager and deputy manager if they could demonstrate that safeguarding alerts had been made in relation to these incidents. They could not confirm that these had been reported to the safeguarding local authority. This demonstrated that suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse were not in place.

We found on 28 October 2014 a service user had been administered the incorrect amount of warfarin sodium. Warfarin is an anticoagulant normally used in the prevention of thrombosis and thromboembolism, the formation of blood clots in the blood vessels and their migration elsewhere in the body. The major side effect of warfarin use is bleeding and may occur if an overdose has been administered. By failing to administer the correct amount of warfarin placed the care and welfare of this service at serious risk of harm. At the time of the inspection, when the administration error was pointed out by us to the clinical lead on duty, they took immediate action and contacted the service user's GP for advice.

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

We saw there was a medication policy and procedure which was attached to the medication administration records. We looked at the medication records for seven people. We saw that two other service users had not been receiving their prescribed medication since the 18 October 2014. We spoke to the agency nurse in charge who told us this was because they couldn't find any of this medication in stock. We found a third service user had not received their prescribed medication since 27 October 2014. We saw on the medication administration record that that this was because 'no medication available-not given.' Failure to

Is the service safe?

administer service users their prescribed medication placed people at risk of harm. These issues were brought to the attention of the clinical lead at the time of the inspection.

We saw a number of people were prescribed 'as and when required' pain relief medication which had been administered as a routine rather than as required. We could not find any evidence that medication reviews had been carried out for these service users. We saw specimen signatures were available for those staff authorized to administer medication. However, these were dated 2 July 2012 and we were told by staff some of these staff no longer worked at the care home.

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

During our inspection we saw that some bedroom carpets were badly stained, for example, one was stained black/ brown with an unknown substance in several places, in another the carpet had been ripped where the door closing device had been catching it, the carpet was also frayed in the doorway here and a potential trip hazard and in a third bedroom the carpet was also heavily stained / soiled. We found in seven bedrooms that a number of toilets in the en-suite facilities were loose in their fixings and a potential risk should these be used by service users as a frail elderly person could easily fall. We saw the garden could not be safely used as an old conservatory frame and glass was being stored there and could be a potential hazard.

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

We looked at four staff recruitment files to see if staff had been recruited safely. In all we found important information had been checked to make sure those using the service were not at risk from staff who were unsuitable to work with vulnerable people. For example, in all staff records we looked at there were references to verify people's previous employment history and satisfactory evidence of their conduct in previous employment. We also saw records which confirmed a Disclosure and Barring Service check had been carried out by the provider for all staff prior to them starting work at the care home. We spoke with the regional manager and deputy manager about how they ensured sufficient staff were on duty. The regional manager told us that they were in the process of introducing a dependency tool so that they could calculate how many staff should be on duty at all times to meet people's needs. On the day of our inspection we saw there was a nurse plus five care staff on duty for eighteen people with dementia living on the first floor of the home, a senior care and two care staff on the ground floor for sixteen people and a nurse and a member of care staff for two people receiving intermediate care. We saw these staffing levels on this day were adequate. A sample of past rotas examined confirmed adequate staffing levels had been maintained.

Service users we spoke with on the ground floor of the home said they felt safe. A visitor told us that if they thought their family member wasn't safe "We would take them somewhere else."

We looked at twelve bedrooms, eight bathrooms and toilets, three communal lounges, two dining rooms, a shower room and a bathroom. We found in a significant number of areas of the home appropriate standards of cleanliness and hygiene in relation to the premises were not maintained. In the lounge in the first floor area of the home all of the communal chairs were heavily soiled and had not been cleaned effectively. For example, there was a red communal easy chair which was heavily stained with debris and dirt on the arms. There was a cushion lying on the floor in this area which was soiled with a wet yellowy substance. In the dining area on the first floor of the home inside the cupboard we saw the toaster was covered in black caked on crumbs. The inside of every cupboard in this area was dirty with splashes of unknown substances and the shelves were ingrained with brown dirt. We examined five dining chairs and found in every one the seat covering and in between the spokes at the base of the seat were ingrained with food debris. In the dining room on the ground floor inside the cutlery drawer, where cutlery was stored, we found deposits of food debris and a used piece of paper towel. The toaster was covered in black caked on crumbs. We examined six dining chairs in this area and saw that each one was stained with particles of food debris both on the arms and on the seat covers. This meant these areas had not been cleaned effectively and therefore people were at risk of infection.

In the majority of bedrooms we found that armchairs were stained as were mattresses and the base of mattresses, with what we assessed to be blood, urine and or faeces. Some of the mattress also had damaged bases and therefore could not be cleaned effectively. In some

Inadequate

Is the service safe?

bedrooms we found a strong unpleasant odour and there was a strong unpleasant odour throughout the first floor of the home. We also found some sheets and quilt covers were stained. We found a wheelchair in one bedroom which was stained under the seat and the frame of the wheelchair was thick with dust / flock.

In the Department of Health guidelines 'The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance' states in relation to criterion 2 'all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.' The observations made by us demonstrated that the home had not been cleaned effectively placing people at risk of infection and that the code of practice issued by the Department of Health in relation to infection control had not been followed.

We asked the deputy manager and regional manager if there was an infection control lead for the home. They stated that at this time there was not an infection control lead for the home. In the Department of Health guidelines 'The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance' its states that an infection prevention and control lead should be identified whose role it is to be responsible for the organisation's infection and control management and structure and be directly accountable to the registered provider'. The observations made by us in relation to the poor state of cleanliness of the environment demonstrated that the provider had failed to ensure an appropriate infection control individual was appointed placing people at risk of infection.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Inadequate

Is the service effective?

Our findings

Service users living on the ground floor of the home said about the staff "They seem to know what they are doing", "More or less they work well as a group" and "The girls are excellent, even the boy is excellent".

None of the staff we spoke with had heard of Dementia Champions or Dementia Friends initiatives. (These are initiatives organised by the Alzheimer's society to improve the lives of people with dementia). There was no evidence that the National Institute for Care Excellence (NICE) guidance 'Dementia Supporting people with dementia and their carer's in health and social care 2006' had been put into practice. For example: We examined the care record for one person. We saw it had been recorded that this person 'may lash out on personal care' with the intervention 'try talking about her parents to distract her'. There was no further detail or step by step guidance to inform staff about what they should do to support this person in a positive way to help avoid this behaviour or what to do when they exhibited this behaviour in order to minimise the risks of escalation. There was no acknowledgement in the care plan that this behaviour was due to this person's dementia nor did the care plan acknowledge their individual needs, background, life history and circumstances. This person's care planning did not demonstrate that a person centred approach to care planning was being adopted in accordance with best practice guidelines.

We saw evidence that service users had access to other health care professionals. For example; a doctor was visiting one person on the day of our inspection. We also saw dentists, chiropodists and other primary health care workers visited service users. However, the advice and guidance given by them had not always been followed. We saw in one service users care records that an occupational therapist had carried out an assessment of their care and welfare needs in August 2014. In this assessment it had been identified that the service user needed 'meaningful activity'. We saw that the occupational therapist had provided the care home staff with a written activity programme for this service user which included hand massage, music, use of fabrics and target games. There was no evidence either from observations made by us of care practice or from the care records examined that the recommendations made by the occupational therapist had been carried out.

We looked at the care records for one person who had been assessed as at very high risk of malnutrition. We saw a nutrition care plan for this person which said 'Usually has her meals in the dining room so staff can prompt her to eat. Can feed herself but can take a long time to eat meals hence losing interest'. On the 27 October 2014 we saw that this service user was in her bedroom on her own with a sandwich beside her at 15.23 pm. We noted again that at 15.48 this person remained in their room on their own and had not eaten this sandwich. We spoke with the agency nurse in charge of the first floor of the home. We asked to see the food and fluid charts for people who had been identified as at high risk of malnutrition. The agency nurse in charge provided us with a stack of food and fluid charts which were arranged haphazardly. We asked the agency nurse in charge how they used this information to monitor that people had sufficient to eat and drink. The agency nurse in charge said that that they did not use this information. She said "Other homes have communication books. It's like a guessing game here". In this way service users were placed at serious risk of malnutrition because their care plans had not been followed by staff and the staff could not demonstrate how people's food and fluid intake was being effectively monitored.

Service users living on the ground floor of the home said about the meals "The meals are rubbish, they are not healthy, the tea is poor, fish fingers/burgers, chips, peas", "I don't like casseroles all of the time. There is no variety" and "There should be more variety, it is all tinned stuff." We shared a meal with people living on the ground floor of home. We saw that most service users left some food and the staff did not ask if they could help or encourage them to eat more. The plates were just taken away. We saw there was no conversation with service users. We looked at the menu and saw there was no choice of hot food at lunch time or evening. The only alternative to the hot meal was sandwiches. We saw there were no condiments or jugs of water on the tables so people could help themselves. These observations and comments from service users demonstrated that people were at risk of inadequate food and fluid intake.

We saw that the physical environment throughout the home did not reflect best practice in dementia care. The NICE Guidelines 'Dementia: Supporting people with dementia and their carers in health and social care 2006' states,

Inadequate

Is the service effective?

'Built environments should be enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment'.

Other than the pictures of toilets suspended from the ceiling there was no evidence of adaptations to the environment to show good practice guidelines had been put into practice. For example, there was little evidence of contrasting colours being used to aid independence, for instance on light switches, grab rails and toilet seats. We asked the deputy manager what model of dementia care had been adopted by the provider, for example social, psychological, or a person centred approach to dementia care. They confirmed that no specific model of dementia care had been used in the care home to guide and inform best practice. This demonstrated that the provider had failed to follow good practice guidelines issued by NICE, the non-departmental public body with the responsibility to develop guidance and set quality standards for social care.

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

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. At the time of this inspection we were informed by the deputy manager that seven DoLS applications had been made. The deputy manager was aware of the recent Supreme Court judgment about people who lived in care home's or supported living arrangements who received 24 hour support and did not go out unsupervised and told us they were working with the local authorities to arrange DoLS assessments for the people who lived at the home. We saw documentation within the care records that we viewed that mental capacity assessments had been carried out for some people.

From the training records we saw that staff had been provided with some training including equality and diversity, health and safety, dementia care, safeguarding adults, fire safety and national vocational qualifications (NVQ) level two in care. However, we saw that three out of the five staff had not had training in relation to the needs of people with dementia or in relation to the MCA or Dols. We saw the home had a policy on the use of restraint. In this policy it stated 'Ensuring that staff receive training appropriate to their level of responsibility and that this be documented and updated as necessary'. We saw no evidence in the staff files we looked at to show that staff had received this training. The deputy manager and regional manager told us they were in the process of reviewing each member of staff's training records and that a plan was in place to ensure all staff received up-to-date training relevant to their roles. We saw records to show staff had received supervision and appraisals to enable them to identify their training needs.

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

Inadequate

Is the service caring?

Our findings

People we spoke with on the ground floor of the home told us "The care is reasonably adequate, I take what is on offer, you get what you pay for," "I think the care is OK but I wouldn't like to be in here for good, it is basically OK," "It is not home but it is alright" and "Oh yes very happy here". Everyone on the ground floor said they had privacy and that they could shut or lock their door. One person said "My door can be locked and shut for my bath." Everyone living on the ground floor of the home said they were treated with dignity and encouraged to be independent. However, one person said "I had a male carer bath me, after the first time they asked if it was alright, I got used to him." No visitors we spoke with complained about the care.

People on the first floor of the home were not treated with dignity or their privacy respected. We saw a list of names of those service users who were at "moderate risk" of malnutrition cellotaped to the dining room wall. We heard one member of staff refer to those people who required a soft diet as "the softs".

The home employed an activities co-ordinator and we saw activities taking place with people accommodated on the ground floor of the home. However, over the two days of our inspection we saw there were no activities for people with advanced dementia living on the first floor of the home.

We spent time with people accommodated on the first floor of the home and carried out a SOFI to capture the experiences of people with dementia who were unable to express this for themselves. This took place for nineteen minutes between 11.52am and 12.11pm in the lounge and further general observations of care practices were carried out by us for approximately twenty six minutes in the dining room located on the first floor between 12.30pm and 12.56 pm. We spent a further four hours observing care practices on the first floor of the home where people with advanced dementia care needs were accommodated. During the SOFI observation we saw there were no interactions between the staff and service users in the lounge for the entire timeframe. The television was switched on in this area, however, no-one was watching it. Three service users were observed during this time frame and all were either asleep or passively watching what was going on around them with no interaction with other people or the environment.

During the two days of the inspection we spent several hours on the first floor of the home and on each day we heard a service user continually shouting out from their bedroom. On no occasion during our observations did any member of staff intervene to alleviate this person's obvious distress. We looked at this person's care plan which said '(name of service user) prefers to stay in his room but then is isolated and this will trigger him to behave badly. (Name of person) will shout constantly for attention and sometimes put himself on the floor. (Name of person) does not understand why he can't have a carer to see to him immediately when he needs it.' Describing peoples' behaviour as 'behave badly' is an example of 'malignant social psychology' (Tom Kitwood 1997) and indicates that staff were 'accusing' or 'blaming' this person for their behaviour rather than demonstrating an understanding of their dementia and how this could impact upon their ability to make sense of their environment.

We found the towels in use were thread bare and did not promote peoples' dignity. People we spoke with told us they had not been involved in writing their care plans. The care records we looked at confirmed this.

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

Inadequate

Is the service responsive?

Our findings

We found there was a lack of person centred information in people's care records. (Person centred means written in a way to describe in an individualised way the best way to support each person taking into account their individual choices, preferences and life histories).

We saw in one person's care records a 'challenging behaviour care plan' which stated '[Name of person] is showing verbal and physical aggression towards staff, using items EG cups, plates, knife to hit, cut staff'. The care intervention dated 1.1.2013 stated 'to receive 500mg lorazepam (a sedative) over next 72 hours'. We saw the care plan had last been evaluated on 7.10.2014 where it stated '[Name of person] continues to display verbal and physical aggression on interventions'. We also saw a behaviour monitoring chart had been completed dated 24.10.2014 which stated that this person can become 'Aggressive bit staff arm'. We saw there was no further information in the care plan of preventative actions staff should take to prevent this person from becoming agitated or of any triggers, thresholds where medication should / should not be given or alternative techniques / strategies. It was also not clear from the care plan if Lorazepam was still in use.

The home employed an activities co-ordinator and we saw activities taking place with people accommodated on the ground floor of the home. People accommodated on the ground floor told us "I go to bingo and sing songs," "I like games and a vicar comes in and the Salvation Army" and "I go out once every now and then." However, over the two days of our inspection there were no activities for people with advanced dementia living on the first floor of the home. There were no items or objects in the lounge of the first floor for people to engage with, for example rummage boxes containing fabrics and materials or items to help stimulate people's memory or to provide sensory stimulation. During the two days of the inspection we found that there was no therapeutic activities at all taking place for people on the first floor of the home which would provide interest or stimulation and help promote positive behaviour and improve peoples' wellbeing. There were no proactive interventions from staff in accordance with The National Institute for Care Excellence (NICE) 'Dementia Supporting people with dementia and their carer's in health and social care 2006.

After our visit to the care home we received information from the Local Authority that showed the home had failed to obtain appropriate equipment that contributed to a person being harmed.

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

The complaints policy was seen on file and the regional manager and deputy manager when asked, could explain the process. The policy provided people who used the service and their representatives with clear information about how to raise any concerns and how they would be managed. People we spoke with on the ground floor of the home said if they had to complain they would tell a carer or the manager if it was serious. They told us "I would tell the manager if it was serious but I don't want to get kicked out" and "I raised an issue before and it was put right in a few days." We asked the regional manager for the complaints log. We saw the last complaint recorded was 21 April 2013. We saw this had been investigated following the policy of the company.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in place, however, they were not present for the inspection. The regional manager later notified us that the registered manager had resigned and that they were actively in the process of recruiting a new registered manager. In the interim period we were told a temporary manager had been appointed.

Service users living on the ground floor of the home told us the staff were happy and the atmosphere was good. They said the staff and registered manager were approachable and they could talk to the manager. However, one person said "The staff complain when they know they have to work nights and they do it in front of residents". Feedback from other professionals demonstrated that this service was not well-led. For example, they told us that action plans generated following commissioning officers visits and visits from the infection control nurses had not been acted upon by the registered manager.

During our inspection we asked the deputy manager and regional manager to describe the quality assurance and monitoring systems in place at Redworth. The regional manager stated he carried out a 'Regional Manager Review' each month. We looked at the records of the monthly reviews he had carried out for May, July, August, September and October 2014. We saw that the 'Key Performance Indicators' monitored each month included the number of accident / incident reports. We saw in the review for July 2014 there had been 40 accidents and incidents since the last visit on 3 June 2014, for August 2014 there had been 27 accidents and incidents since the last visit on 29 July 2014 and in September 2014 there had been 26 accidents / incidents since 18 August 2014. There was no entry made in the 'Comments' section / box next to the number of accidents / incidents to explain why there had been such a high number of accidents and incidents within this time frame nor was there a record of any judgement, follow up or preventative action documented to reduce the risk of these occurring.

We saw that the number of accidents and incidents individual service users were involved with were monitored each month. We found in the record of monthly reviews carried out by the regional manager that a service user had been involved in four accidents / incidents between 3 June 2014 and 29 July 2014, six accidents / incidents between 29 July 2014 and 18 August 2014, five accidents / incidents between 18 August 2014 and 11 September 2014 and six accidents / incidents between 11 September 30 October 2014. We saw in the 'Comments' section / box next to the number of accidents / incidents this person had been involved in it had been recorded by the regional manager 'Resident is quite active and this causes some friction with other residents. Staff aware and observing.' There were no further records of the preventative actions the registered manager or regional manager had taken to reduce the risk of this person from being injured or harmed despite there being 17 incidents / accidents recorded as having taken place over the previous period of four months.

We also saw that a second service user had been involved in three accidents / incidents between 3 June 2014 and 29 July 2014, five accidents / incidents between 29 July 2014 and 18 August 2014 and three accidents / incidents between 18 August 2014 and 11 September 2014. We saw in the 'Comments' section / box next to the number of accidents / incidents that this person had been involved with it had been recorded by the regional manager 'Observations in place.' There were no further records of the preventative actions the registered manager or regional manager had taken to reduce the risk of this person from being injured or harmed despite there being eleven accidents / incidents recorded as having taken place over a period of three months.

This demonstrated that the system used by the provider to investigate and respond to the number and circumstances that service users living at the home had sustained accidents and incidents was ineffective. The provider was unable to demonstrate that the number and circumstances of accidents and incidents had been analysed and where necessary changes had been made to reduce the likelihood of reoccurrence in order to improve the service and protect people from potential harm.

During our inspection we found in a significant number of areas of the home appropriate standards of cleanliness and hygiene in relation to the premises were not maintained. This exposed service users, persons employed and others who may be at risk to a health care associated infection arising from the regulated activities, to the risk of infection. We saw in the 'Regional Managers Monthly Review' for 29 July 2014, 11 August 2014 and 11 September 2014 a recording had been made under the heading 'Environment-General Appearance and Maintenance,' which stated 'The home was clean and tidy with no odours

present.' We saw that an 'Infection Control Audit' had been carried out by a Registered General Nurse on 24 October 2014. In this audit under section 'General Environment', 'Overall appearance is tidy and uncluttered with only appropriate clean and well maintained furnishing', we saw a tick had been recorded under the heading 'Standard Partially Met'. We saw in the 'Comments' section / box there was no recording made to indicate why this standard was partially met and what action needed to be taken, by whom, or when to ensure the standard was fully met. We also saw under the section 'Fabrics of the environment smell clean fresh and pleasant' a tick had been placed under the 'Standard Fully Met' heading. Three days after this audit we found a different result. These reviews should have identified the on-going condition of the home and alerted the registered manager and regional manager that service users were placed at risk because of inadequate maintenance, repair and cleansing at the home.

The Local Authority had informed us of safeguarding incidents that had taken place and the results of their investigations identified poor standards of care. The internal audits we saw had failed to identify any of these concerns.

This is a breach of 10 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2010.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the Regulation was not being met: People who use services and others were not protected against the risks associated with unsafe use or management of medicines. Regulation 13.

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 How the regulation was not being met: Arrangements were not in place to treat people with dignity and respect. Regulation 17(1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: People who used services and others were not protected against the risks associated with unsafe use care by staff who had not been appropriately trained. Regulation 23(1) (a).

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 How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

Service users were not protected against the risks of unsafe or unsuitable premises because adequate maintenance was not in place. Regulation 15(1) (c).

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: Bondcare Shaftsbury Limited had failed to take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by the planning and delivery of care, in such a way to meet service users' needs and ensure their welfare and safety as a result. For the purposes of 9(1) (b) (iii) there has been a failure by the provider to reflect best practice guidance in relation to such care and treatment relating to dementia care issued by NICE, the non-departmental public body with the responsibility to develop guidance and set quality standards for social care, as outlined.

The enforcement action we took:
We issued the provider and registered manager with a Warning Notice. We required the provider to be compliant by 9 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: Bondcare Shaftsbury Limited had failed to take proper steps to ensure that appropriate standards of cleanliness and hygiene in relation to the premises were maintained.

The enforcement action we took:
We issued the provider and registered manager with a Warning Notice. We required the provider to become compliant by 9 January 2015.

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 provision

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met:

Bondcare Shaftsbury Limited had failed to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to regularly assess and monitor the quality of the services provided and identify, assess and manage risks relating to the health, welfare and safety of service users.

The enforcement action we took:
We issued the provider and registered manager with a Warning Notice. We required the provider to become compliant by 9 January 2015.

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 provision

How the regulation was not being met:

Bondcare Shaftsbury Limited had failed to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to regularly assess and monitor the quality of the services provided and identify, assess and manage risks relating to the health, welfare and safety of service users.

The enforcement action we took:
We issued the provider and registered manager with a Warning Notice. We required the provider to become compliant by 9 January 2015.