Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Manor Park Care Home

Leeds Road, Cutsyke, Castleford, WF10 5HA

Tel: 01977604242

Date of Inspection: 04 August 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✖ Action needed
Cleanliness and infection control	✖ Action needed
Management of medicines	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Countrywide Care Homes Limited
Registered Manager	Ms Patricia Blenkinsopp
Overview of the service	Manor Park is a purpose built care home that provides both residential and nursing care for up to 75 people. There are three separate units within the home divided into nursing care, residential care and care for people living with dementia.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 August 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information sent to us by other authorities.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

The inspection visit was carried out by two inspectors and an expert by experience. During the inspection, we spoke with the quality manager, the deputy manager, four care assistants, the maintenance person, three kitchen staff, 14 people who lived at the home and 5 relatives of people who lived at the home. Not all of the people we spoke with who lived at the home were able, due to complex care needs, to tell us about their experience of living at the home. We observed care given to people in the communal areas, including lunch, and in their bedrooms. We also also looked around the premises, observed staff interactions with people who lived at the home, and looked at records. There were 72 people living at the home on the day of the inspection, this included 21 people living with dementia.
We considered all the evidence we had gathered under the outcomes we inspected.

We used the information to answer the five key questions we always ask;
- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well led?

This is a summary of what we found. The summary describes what we observed, the records we looked at and what people using the service, their relatives and the staff told us.

If you want to see the evidence that supports our summary please read the full report.

Is the service safe?

Care was not planned and delivered in a way that ensured people's safety and welfare. There were insufficient numbers of suitably qualified staff to meet people's needs. We have asked the provider to make improvements.
People were cared for in an environment that was not clean and hygienic. This meant people may not be protected from the risk of infection because appropriate guidance had not been followed.

One person's relative told us, "There are no staff to watch people in the main lounge of the nursing unit. People are unable to summon help if they need it".

We observed an incident occur on the unit for people living with dementia. Staff did not take appropriate action to prevent a reoccurrence, did not document the incident in a timely manner, or refer the incident to the local authority safeguarding team in a timely manner.

Peoples' medicines were stored in rooms which were above the required temperature and medicines were not managed safely. This meant vulnerable elderly people were being put at risk.

Is the service effective?
The service was not effective. The home did not promote a good quality of life for the people that lived there.
We looked at six people's care files. We saw that some important documents within people's care records had not been completed.

People were not supported with diet and fluids to support their health. This meant people were not protected from the risks of inadequate nutrition and dehydration.

Audits were not effective; they either failed to identify issues or failed to follow up on issues when they were identified. This meant peoples' care needs were not being met.

Is the service caring?
On the unit for people living with dementia, we saw people were supported by staff who did not appear to have the necessary skills to meet their care needs. However we did see some staff to be patient and encouraging when supporting people.

Relatives we spoke with told us they were not happy with the care provided at the home. One person's relative told us, "The staff here are not good. I'd say about 90% of them do not care. We have raised concerns with the manager and nothing changes. It's not nice when you come to visit and your relative smells and has dirty finger nails. It's just not good enough."

One person who lived at the home when asked what they would do if they were unhappy said "I wouldn't bother saying anything, I don't think anyone would care."

We saw some people displaying signs of distress but staff did not intervene. One care assistant said to us "That one just says 'nurse', 'nurse', 'nurse' over and over."

Some care assistants we spoke with told us they felt frustrated at the restrictive practices in place at the home. For example, on the unit for people living with dementia people's toiletries had to be stored in a cupboard and not in the person's bedroom. People also had

to have their meals and drinks out of plastic plates, bowls and cups. However, when we looked in people's care records we saw there were no risk assessments in place to address this.

When we looked around the residential unit of the home we saw people's bedrooms had been personalised and contained personal items such as family photographs. However, on the unit for people living with dementia we saw people's rooms were stark with very little in them. We were told by staff on this unit that people's bedroom doors were locked on they had got up in a morning and people had to ask staff to let them back into their rooms. They told us this was to ensure people did not wander into other people's bedrooms. However, for people living with dementia this may be difficult and meant they were limited to where they spent their time.

Is the service responsive?
We heard call bells going off for long periods during our visit. We also saw several call bells which were out of reach in bedrooms and bathrooms we looked in. We noted that call bells were not in reach of people in the lounge areas. Two visitors told us they have seen people in wheelchairs have to wheel themselves to the call bells to summon help for people who are not able to mobilise.

All of the people we spoke with, including relatives and visitors, told us that there were not many activities for people to engage with. One person said, "There's not much to do except watch TV." One relative said, "I've never seen much going on in the way of activities. When we asked people who lived at the home about what they did to pass the time. None were enthusiastic in their responses. One said "Sometimes there's bingo, I go to that if I feel like it. I don't know whether it is on today, though." Another person said "I would love to dance sometimes." We asked whether anyone ever put music on and encouraged them to do this. They said "No, never. But that would be lovely."
We asked people in the upstairs lounge about their access to the garden. One said "I'd like to go out there, especially when it's warm. We don't get to do it very often though." Several people who lived at the home used the word "Boring" to describe their experience of living in the home. One said "I'm bored to tears. I just want to get out of here."

We found the complaints system at the home was not effective. Comments and complaints people made were not responded to appropriately.

Is the service well-led?
The service was not well-led. People were not protected against the risks of inappropriate or unsafe care. The provider had a system in place to assess and monitor the quality of the service people received however, when issues were identified through audits we were unable to see that actions had taken place. This meant the system of audit within the home was not effective. The leadership on the unit for people living with dementia and the nursing unit at the home did not assure the delivery of high quality, person centred care. When we asked care assistants why some practices were in place they said it was just what they had been told to do.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 11 October 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We looked at six peoples' care records from the three units and found very little evidence of either the person, or their relatives, being involved in care planning. For example, we saw consent forms, care plans and pre-assessment documents with spaces for the person, or their relative, to sign. We saw these spaces were blank. This meant people, or where appropriate their relatives, had not been involved in their care planning. We saw that care plans had been reviewed on a regular basis but again did not see evidence of the involvement of the person or their family. The quality manager told us they had encountered problems involving families but were looking at ways to do this effectively.

In three of the care records we looked at we saw documents in place for the purpose of enabling the person to have their wishes to be met regarding their end of life care. We saw that none of the documents had been completed apart from the person's name. Having an end of life care plan in place increases the likelihood that the person who uses the service's wishes are known and respected at the end of their life.

In all of the records we looked at we saw a booklet titled 'Me and my life'. The document allowed for recordings to be made about the person's life history. For example what the person's favourite TV programme was, food and drink they liked and disliked, activities they would like to get involved in. We saw in five of the records we looked at that this document had not been completed. We saw in one person's file that the 'Me and my life' had been completed by family. When we asked staff if they were aware of the information in it they said not. This meant that staff were not aware of the person's preferences, interests and previous lifestyle.

Care staff on one of the units told us they were organised to support people on a daily basis whose rooms were situated on one of the two corridors. They said they only really knew about the current needs of the people they had been assigned to support on that day. This did not indicate that an effective key worker system was in operation.

On one unit we saw nine people sitting in the lounge for just over ten minutes with no staff presence. When a staff member came into the lounge it was to return a person in a wheelchair who had been out. They did not engage with any of the other people in the lounge. We spoke with three people who all told us they were bored. One person told us "This is how it is. We're put in here and left to get on with it. It's boring, I'm sick of it." Another person told us "I don't know where the staff are or what they're doing. Not looking after us that's for sure."

We saw there were two call bells in place on the walls at opposite ends of the room. They were not within the reach of people in the room. This meant people did not have a way of summoning help if they required assistance.

On another unit we saw that although staff were present they were not responding to one person's request for the toilet. They were calling out that they 'needed to go'. We spoke with one member of care staff who said 'they'll have to wait I'm seeing to someone else." We saw that this person was becoming more upset and eventually another staff member attended to them. We saw one person repeatedly banging on a handrail but staff did not speak to them or try to engage them in any activity. Several people were vocalising repeatedly but staff did not make any effort to speak to them or distract them.

On the third unit we heard a person shouting "Nurse" repeatedly from their bedroom. We asked the person if they were alright. They said they needed the toilet urgently. We alerted the nurse who said they would ask the care assistants to attend. We saw it was another ten minutes before the person was attended to. We heard the person say "it's too late; I've made a mess now, oh dear".

We saw from records that people had access to healthcare professionals. However, we saw from care one person's care records that the physiotherapist had advised the person needed to be encouraged to mobilise with their walking aid. This person's visitor had told us this did not happen and we did not see a care plan detailing the support this person needed to maintain their mobility. We saw staff used a wheelchair for mobilising this person during our visit.

We found that care plans did not reflect the care people and their families told us they needed. For example we saw a care plan which said the person would ask for support to go to the toilet when they needed to. The person's visitor told us they did not do this and as a result was frequently incontinent. Daily care records supported this information.

On the unit for people living with dementia we saw there was a 'Day board' in place. This was intended to hold details of what day and date it was. We saw that it had not been completed and only had '2014' written on it.

People were seated in the lounge and dining area having their breakfast. We noticed that very loud music was on. This compromised the opportunities for social interactions during breakfast between people and care staff.

We saw that people on the same unit did not have any toiletries in their en-suite areas. We

asked two staff members about this and they told us they people weren't allowed to have these items in their rooms as they may drink the liquids. We asked the staff if there had been any incidents of this happening. They told us this had never happened but it was what the management had put in place so they did it. They also told us this made it difficult for them when they were assisting people as they had to return to the place where the toiletries were stored to get any extra items required. We looked at where the items were stored and saw that people had small plastic baskets, some were named others were not. We saw some of these were very full and this meant items were spilling out. This meant that people's toiletries were at risk of being used by other people. Staff said that soap was not provided by the home. Toiletries provided were shampoo, shower gel and razors. We saw these were all purchased from the same supermarket and were in the 'budget range' in terms of price. One staff member told us they often brought in 'decent' razors for people as the ones provided by the home cut people's skin.

During the afternoon we observed a gentleman asking care staff to support him with a shave. The person asked repeatedly. When we asked care staff why he had not been supported to shave, they said they didn't have any razors. We raised this with the quality manager who told us razors were available and organised for some to be sent to the unit.

Some of the relatives we spoke with told us they had concerns about the support people were given with their personal hygiene. Some of the people we spoke with did not appear to be to have been well supported with maintaining their personal hygiene. For example one visitor told us their relative often smelled strongly of urine and body odour. We found this to be the case during our visit.

Staff on the dementia care unit told us that when people got up in the morning and left their rooms staff locked people's bedrooms. They said this was due to some people on the unit going into other peoples bedrooms and tampering with their possessions. They also told us this meant that people would have to ask for their bedrooms to be unlocked if they wished to return to them during the day. For a person living with dementia this would present difficulties and therefore restricted their choice of where to spend their time.

When we looked in the care records of two people who were living with dementia we found there were no risk assessments in place. We spoke with the nurse as both people had been observed eating from plastic crockery, having no access to their rooms without having to ask a staff member and were also not permitted to have access to their toiletries. The nurse looked through both of the care records with us and confirmed there were no risk assessments in place and that there should have been.

We saw people spent their time walking around the units or sitting in one place for long periods of time. Staff appeared to be 'task focused' rather than focused on interactions with people which were meaningful. For example we observed staff supporting a person with the hoist with minimal interaction, explanation or reassurance.

We saw an activities plan on display in the reception area for the whole home. However, we saw this was still showing activities for July 2014. A nurse told us the two members of staff who provided activities within the home were both off duty in preparation for a trip out for six people later in the week. Care staff did not appear to make any effort to provide people with any stimulus other than leaving the television on. We did not observe anyone actively watching any of the sets on the communal areas during our visit.

We asked people about what they did to pass the time. None were enthusiastic in their

responses. One said "Sometimes there's bingo, I go to that if I feel like it. I don't know whether it is on today, though." Another person said "I would love to dance sometimes." We asked them whether anyone ever put music on and encouraged them to do this. They said "No, never. But that would be lovely."

We saw in one person's records a document in place for the purpose of recording activities the person had taken part in. We saw that nothing had been recorded for 2014.

This showed the service was not meeting the social needs of people who lived at the home. The delivery of care, treatment and support should maintain people's welfare by taking account of all their needs. This should include people's mental, social, and emotional needs, including daytime activities.

Meeting nutritional needs ✖ Action needed

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our visit we saw examples of people not being supported to enjoy a nutritious diet and receive adequate fluid intake.

At approximately 10.30 am we saw a person sitting in their bedroom. They had a table in front of them which was very dirty and too high for the person to reach comfortably. On the table was a plastic plate with bacon and tomatoes on it. The person was eating with their fingers and when they pushed some of the food off their plate we touched it and found it was cold. We saw some food had been dropped down the side of the chair. The person told us they had not had a drink and there was no cup in their room. We went to fetch a member of staff. They told us they thought the person had been given a drink. They asked the person if they had finished their meal, the person did not answer but continued to put their fingers in the meal and to their mouth which indicated they were still eating. The staff member picked up the plate to take it away.

We saw another person in bed. They did not have a drink available to them. We asked if they were alright and the person said they needed a drink. We asked staff to provide this person with a drink.

During lunch on the dementia care unit we saw several people who lived at the home eating in a corridor, with one member of staff accompanying in them. The staff member was not able to support people individually and an altercation occurred between two of the people. This meant the dining experience for these people was poor.

We saw lunch brought to the kitchen area of another unit. Two care staff came into the area and we asked them how many people they were caring for today. One of them told us they did not know and asked the other staff member to go and have a look. A number of people living on this unit were being nursed in bed and had complex care needs. We were concerned that staff did not know how many people they needed to support with their lunch.

We saw seven meals had been plated up by the member of kitchen staff and placed on the serving counter. The meals had a large amount of gravy poured over them. People

had not been asked what they would like on their plate or if they would like gravy.

Four people were seated in the dining room at tables and despite seven meals being plated up and left on the counter for over five minutes, we saw it took at least ten more minutes for them to receive their meal. One person said "I'm not eating that" when their meal was put in front of them. They were not offered an alternative and therefore did not have a meal.

The serving of the meal was disorganised with staff leaving the dining area to attend to people in their rooms. This meant people in the dining room had to wait for assistance. There were no condiments available and the tables had been set without knives. We heard one person ask for some salt and saw they had to ask another two times before they were given any.

On the unit for people living with dementia we saw that plastic plates and bowls were used for everybody. When we asked why, a member of staff said "People are at risk on here. We honestly can't let them have crockery as they would just throw it and smash it." We asked one member of care staff if people who were at risk of smashing crockery had risk assessments and care plans in place for this. The staff member told us they did. However, when we looked in two people's care records we were unable to find any evidence of a risk assessment being completed for this purpose. Nor did either person have a care plan in place to give staff guidance on how to support the individual concerned.

We saw there was one option of the lunchtime meal being served to people throughout the home. We asked the kitchen staff to show us the documentation which showed meal choices people had made. They said this was not done. They told us there was an alternative option available for lunch. However, we did not see anyone offered this choice.

We saw information displayed in the kitchen regarding how many meals were required to be pureed or softened. We saw that only one option of pureed or soft lunch was available to people and it was served from one bowl. This meant people were not having meals presented to them in an appetising way and were not given choice of meals.

We asked the kitchen staff what snacks were available for people who had specific health needs such as diabetes. They told us they did not have anything to offer people who required low sugar foods.

We had seen from one person's care records that the dietician had requested the person receive fortified drinks throughout the day and that their meals be fortified. We asked kitchen staff if they received information from care staff regarding people who were losing weight and needed their meals to be fortified. They told us they did not. We asked what they used to fortify meals. They said they may put a 'bit of cheese' on a person's meal but as a rule they did not fortify people's meals. Care staff also confirmed to us that people did not have their meals fortified. This meant people who required extra calories due to weight loss did not receive a level of nutrition which met their health needs.

We saw evidence in one person's records which showed they required their level of nutritional intake to be monitored due to recent weight loss. We saw the person' 'Nutritional assessment' showed the person had lost 5.25kg over a six month period. We were told by staff they were completing 'Daily recording of intake for this person. On the day of our inspection the recordings made by staff stated what the person had eaten but not the amount. For example, "Breakfast – Porridge, jam and bread. Lunch – mash, chicken, veg,

pud." We saw at the top of the document it stated "detail the amounts taken in measureable amounts – teaspoons, scoops, slices, mils". As the documentation had not been completed correctly it was not possible to assess from them if the person was receiving an adequate level of nutrition. We spoke with the quality manager about this and they told us the provider was looking for more suitable document to use for recording people's nutritional intake.

We saw in the same person's records a care plan for nutrition. The care plan stated 'X requires a high calorie diet rich in protein. Should be offered milk and milk based drinks on a regular basis. Finger foods to be offered'. When we looked at recordings made of what the person had eaten over the last seven days we saw they had been given five glasses of milk by staff but had refused thirteen meals and snacks over that period. There was no evidence of finger foods being offered.
We saw this person eating their lunch in the reception area of the unit. They were sat with two other people who also lived on the unit. We saw the person appeared to be having difficulty sitting to eat their meal and would get up and walk away before coming back and sitting again. One of the other people who was sitting with them would also get up and try to bring them back. This caused some distress to the person and we observed them telling the other person to leave them alone. There were no staff present to intervene or to monitor the person's food intake.

At 3.30pm we spoke with a person who stayed in their room due to on-going treatment. We saw that the person's lunch time crockery was still in their room. The main meal appeared untouched but the pudding had been eaten. This demonstrated that staff were not vigilant about people's dietary intake.

People we spoke with were generally positive about the food that they were given, but none were aware of what the day's menu was or whether they had choice. One person said "I eat just about anything so it doesn't matter to me." Another said "The food is ok – I don't remember what I had for lunch but I think I ate it all." We asked people about what they would do if they did not like what they were given. One said "I don't know – I suppose I would just eat it." Another said "I think they'd make you some toast or something, but you have to wait until they have finished serving everyone else."

People told us they did not receive drinks and snacks between meals. Two visitors we spoke with said they would make their relative a drink and sometimes made other people drinks because they felt sorry for them and they asked them to do this. Both relatives said they worried about doing this because they didn't know if people had special requirements. We did not see any between meal snacks and drinks served. On one unit we saw the catering staff had left a plate of biscuits for the afternoon snack. These were not served.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People were not cared for in a clean, hygienic environment.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not effective systems in place to reduce the risk and spread of infection.

During our visit we looked in some bedrooms, bathrooms and all of the communal areas.

We saw one person sitting in their bedroom eating their breakfast. We saw a piece of faeces on the carpet at the side of the person's chair. This appeared to have been trodden in. When we had to call a member of staff to the room to attend to the person they made no attempt to clean this up.

When we looked in other bedrooms on the same unit we found there were other areas which were dirty and in need of repair. We saw door plates were missing, torn flooring, dirty and stained bed linen and in one person's room a very dirty sock tucked in with the bottom sheet.

We found upholstered chairs in some people's bedrooms were stained and dirty.

Around the main corridor of the unit we saw the handrail which some people used to assist them as they walked on the corridor, was very dirty with bare wood showing in some areas. This meant it was difficult to clean. We saw dirty door frames, skirting boards, walls and window frames throughout the unit.

In one bathroom we saw the window frame was very dark in colour and appeared 'smoke damaged'. However, this was not the case and we saw it was badly stained and dirty. The bath in that room was also dirty.

On one unit we found a shower room where the shower tray was filled with black particles and dirty water. The smell from this room was very unpleasant and extended into the corridor. We brought this to the attention of the quality manager who told us the room was not in use. They also told us the domestic staff had emptied their mop buckets into the shower tray. We saw the shower head was detached and asked if the water outlet was tested regularly. We saw evidence recorded by the maintenance person that this was

tested on a weekly basis. There was no sign to indicate the room was not in use.

We saw faeces on the floor in one of the corridors. Although staff were frequently walking up and down, they did not clean it up.

We saw toilets and hand wash basins were not clean and the sink in one of the treatment rooms we entered was very dirty.

Some of the lounge chairs were stained and two of the inspectors found their clothing smelled of urine after sitting in these chairs.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Medicines were not kept safely.

During our visit to the service we looked at the systems in place for the receipt, storage and administration of medicines on two of the three units of the home.

On one unit we looked at the Medication Administration Record (MAR) charts and medicine stocks for 6 people.

We saw from one person's chart that they had been prescribed tablet Lorazepam to be taken twice each day. We saw the times indicated on the MAR chart for administering this tablet had been identified as 9am and 10pm. We saw that for nine days the tablet had been administered at 5pm and 10pm. We did not see any reason recorded for this. We also noted that on three days the tablet had been given three times a day. This exceeds the prescribed dose. We asked the nurse in charge about this. They said the tablet was given at 5pm and 10pm because the person became agitated during the afternoon. We asked if there was record that the prescribing doctor had been consulted about this. The nurse said not. The nurse was unable to give an explanation as to why the tablet had been administered three times instead of the prescribed twice on three days.

We looked at another person's MAR chart which included a prescription for Paracetamol tablets to be given four times each day. This was not a PRN (as required) prescription and therefore should have been given as prescribed until reviewed by the prescriber. We saw that for the previous nine days the Paracetamol had only been administered twice each day. No reason had been recorded for this. The nurse said it was because the person didn't want it. No record had been made of this.

The majority of medicines were supplied to the home in a monitored dose system. Others were supplied in boxes.

We looked at stocks of boxed Paracetamol for four people. We found that the amounts

recorded as received did not tally with the amounts held in the medicine trolleys and cupboards. For example, one person's MAR chart showed that 224 Paracetamol had been received at the home on 25 July 2014. There was no record of any stock already in the home. We found stock totalling 448 tablets for this person. We found exactly the same for another person. Another person's MAR chart showed that 100 Paracetamol tablets had been received on 25 July 2014. We found a stock of 270 Paracetamol tablets for this person.

This meant that no accurate records were being maintained of medicines held in the home. This made it impossible to reconcile the amounts received against the amounts recorded as administered and the stock balance.

When we went into the room where medicines were stored on the second unit we noted that the thermometer indicated a room temperature of 30 degrees C. We looked at five different medications, including an anti-biotic, all of which had the instruction "Do not store above 25 degrees C" This meant that the medicines may have been adversely affected by the room temperature and therefore not have the therapeutic affect intended.

We also saw large amounts of medication in boxes and bags on the floor of the room. The nurse told us they were for return to pharmacy. However we saw some of the medication did not have the labels detailing who the medication had been prescribed for attached. We asked the nurse how they would document the return to pharmacy when they didn't know who the medication had been prescribed for. The nurse said they didn't know.

This meant that safe systems were not in place for the storage and management of medicines in the home.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not enough qualified, skilled and experienced staff to meet people's needs.

During our visit we observed several situations when staff were not available to people when they needed support, These included an aggressive incident between people who lived at the home, people shouting for the toilet and people needing support with meals.

We saw there were long periods of time when staff were not available in communal areas. A visitor we spoke with about this said "It's normal, there's usually no one in here."

Another visitor told us they have witnessed many times when people have needed help and staff are not available.

A person who lived at the home said "They are always very busy." Another said if I press the buzzer in my room sometimes they take a while to come – they will always apologise and explain, and I know they have lots of people to deal with. It's when they've lifted me onto the toilet and then I have to wait for them to come and get me off, that I don't like so much. It reminds me that I'm totally dependent on them now."

All of the staff we spoke with said they were very busy and felt there were not enough of them to safely meet the needs of the people living at the home. One member of staff said they had raised concerns about staffing levels but nothing had changed.

One person who lived at the home said "No, I don't feel safe here. I don't feel that I've anyone to turn to if I need to." Another said "I don't know where the staff are or what they're doing. Not looking after us that's for sure."

Some of the people we spoke with felt the staff were caring one person said "She's very nice and he is someone I can have a laugh with." Another said "It depends who you are asking about. Some are very good, they take their time and ask me whether I'm happy with what they are doing. Others are more like Sergeant Majors and tell me what I have to do. There's no asking."

One visitor told us "The staff here are not good. I'd say about 90% of them do not care. We have raised concerns with the manager and nothing changes."

We saw that a lot of the people living at the home had complex needs and therefore were highly dependent on staff. Arrangement of staffing within the home should be based on the dependency needs of the people living at the home.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We returned to the home the second day to look at how the home monitored the quality of the service.

We saw there was a schedule of audits in place which were planned to take place over 12 months. These included audits of medication, infection control, health and safety, kitchen, dining, safeguarding, staff meetings, resident and relative meetings, home presentation audit, provider compliance assessment, business contingency plan and a full review called 'In pursuit of excellence.' We also saw that training records, maintenance records and expense claims were checked on a regular basis.

We looked at records of accidents and incidents for May, June and July 2014. We saw there had been 18 falls which had not been witnessed by staff. We looked at the actions taken to prevent reoccurrence on the incident forms. On some of the documents we saw there had been a referral to the falls team however; on the majority of documents we looked at, this section was left blank.

There was evidence to show incidents at the home were being monitored and analysed over time however; there was no evidence that patterns and trends of accidents and incidents were being analysed. Trend analysis of incidents that may result in harm to people allows changes to their care and treatment to be made where needed. It is good practice to analyse trends in incidents as part of continuous quality improvement and any lessons learned should be shared with staff.

We spoke with the maintenance person who showed us evidence of water testing within the home. This was taking place on a weekly and monthly basis. We saw records which showed outlets throughout the home were being tested and actions taken were there were issues. We also saw that water temperatures were being tested as part of these checks.

We looked at complaints received by the home in the last 12 months. We saw that two

complaints had been received. These had been recorded in the complaints file and the response details were also present. However, for one of the complaints there was no record of whether the complainant had been satisfied with the outcome of the investigation. Records in place also did not show that the complaint had been resolved.

We did not see any evidence regarding any concerns raised within the home although we had spoken to a relative who told us they had raised concerns. The relative told us that no changes were made as a result of raising concerns.

We looked at the results of the 'Visit by Provider' audits which took place at the home on a monthly basis. In May 2014 we saw that concerns had been raised regarding the temperatures of the treatment rooms within the home where medications were stored. We also saw for July 2014 this issue was also recorded. One of the nurses we spoke with told us they could not spend time in that room due to the high temperature. They told us it was 30 degrees centigrade. There were no cooling units in this room. This meant the provider had not taken action to resolve this issue.

We looked at the results of the visit in June 2014 and saw observations had been made regarding both members of activity staff being on annual leave at the same time. This meant there were no activities being provided to people living at the home. The result of the audit stated "There should be facilities so that other staff members can provide activities when this situation arises again." The action plan in place for this had a timescale of one month set so that the manager could put actions in place. However, on the day of our visit we were told that the activities staff were on leave or off duty. We saw this impacted on the delivery of activities within the home and no arrangements had been put in place.

We looked at the results of care plan audits which had been carried out in June 2014. We saw that a range of issues were identified regarding the non-completion of documents, lack of evidence of involvement of people and/or their relatives in the care planning process, no record of communication with relatives and actions not put in place where a person and/or their relatives did not wish to engage with the life history document for the person. We saw that where issues had been identified there had not been a person identified to carry out the actions required, nor had a timescale been set for the completion of the actions.

We looked at the results of a dining audit carried out on 26 June 2014 on the dementia care unit. We saw from the observations made a number of issues were still continuing. For example, 'are alternatives to the published menu made known to residents when either pre-ordering or selecting meals' this was not achieved. 'Are residents encouraged and supported to exercise choice when ordering/selecting meals especially those residents who are on special diets' this was recorded as partly achieved as residents could only choose sometimes. 'Are tables/trays prepared with the correct tableware, cruets (where appropriate) and napkins. The result stated 'no condiments out but available if needed by residents and none out on tables – not always appropriate. The overall results of the audit highlighted there was no enough choice available and food was not presented well but this was due to the 'blandness' of the food available.

The manager had stated they had booked a meeting with the cooks however we did not see the minutes. From the observations we made on the day of our visit we saw there had not been any changes made to the dining experience for people living on this unit.

We looked at the most recent Infection Control audit within the home which was carried out by the local authority team in November 2013. The results of this overall were 85%. This meant improvement was needed. We saw the home had been re audited in May 2014 and most areas which had been identified previously were improved. However, there were still improvements required in relation to client equipment i.e. mattresses used by people living at the home and areas of the home which required repair or redecoration. The overall score for this audit was not available however; the home is due to be re-audited in full in November 2014.

We looked at the most recent audit of people's dependency within the home. We saw the audit consisted of 11 questions to be answered regarding assistance people required. For example, how often they experienced continence problems and what their behaviour was like. We saw that each person received a score for each question however; there were no results available. This meant that although the provider was measuring the dependency of people, there was no evidence to show this was having an impact on the care provided.

We looked at training records for staff which showed the majority of staff were up to date with fire awareness, manual handling, food safety, first aid, safeguarding of adults, infection control, dementia, MCA and DoLs and COSHH. This showed staff had the appropriate knowledge and skills to perform their job roles.

We asked to see evidence of how the home sought feedback from the people who lived at the home and their relatives. We were told by the administrator the home's annual satisfaction survey had been sent out in July 2014 and the results were still to be gathered and reviewed. This meant the views and opinions of people who used the service and/or their relatives were sought.

Although auditing was taking place we found that it was not effective.

Examples of this included the comments people who lived at the home made to us about the lack of stimulating activity and slow or poor response from staff when they needed support.

We also did not see any evidence that concerns made by relatives had been responded to appropriately.

Effective auditing would also have highlighted issues relating to people's dining experiences, problems with storage of medication and poor standards of hygiene.

We were also concerned that issues such as people not having toiletries in their bedrooms were unknown to the quality manager.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures 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: People did not always have their care and welfare needs met.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs**
	How the regulation was not being met: People were not protected from the risks of inadequate nutrition and dehydration.
Regulated activity	Regulation

This section is primarily information for the provider

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: People were not cared for in a clean, hygienic environment.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: Medicines were not stored or managed safely.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not enough qualified, skilled and experienced staff to meet people's needs.
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: Auditing was taking place but was not effecting changes where a need had been identified.

This section is primarily information for the provider

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 11 October 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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