Cliffe Vale Residential Home Limited

Cliffe Vale Registered Care Home Limited

Inspection report

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Ratings

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

Overall summary

The inspection took place on 21 October 2015 and was unannounced. There were 25 people living at the home at the time of the inspection.

Cliffe Vale is located close to the centre of Shipley. The home provides personal care to a maximum of 27 people and caters predominantly for older people and people living with dementia. The home is a detached property and provides accommodation on three floors, the home does not have a passenger lift, there are a number of stair lifts which provide access to the upper floors.

The home has a registered manager. 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 2008 and associated Regulations about how the service is run.

The last inspection took place on 29 October 2014. At that time we found the provider was not meeting two regulations. These were the regulations relating to the Mental Capacity Act 2005 and monitoring and assessing the quality of the services provided. The provider sent us an action plan with details of how they were going to make the required improvements. They told us they would have completed the action plan by February 2015. New regulations came into effect on 01 April 2015 and we cross referenced the old regulations to the new regulations so that we could check the provider had taken appropriate action. We found the provider had not taken appropriate action and there were breaches of the new regulations.

We looked at how the service was working to meet the requirements of the Mental Capacity Act 2005 and found people were at risk of being deprived of their liberty unlawfully. This was a breach of the regulations because people must not be deprived of their liberty without lawful authority.

People living in the home and their relatives told us they felt safe. However, we found safeguarding incidents were not always recognised or reported to the right agencies, such as the Local Authority safeguarding team and the Commission. This was a breach of the regulations because it meant the provider did not have proper systems in place to make sure people were protected from abuse.

The provider did not always make sure the required checks were completed before new staff started work. This was a breach of the regulations because it meant people could be at risk of receiving care and treatment from staff who were not fit and proper persons to work in a care setting.

There were no housekeeping or laundry staff employed at the time of the inspection. The cook finished work after lunch and the activities coordinator only worked two hours a week. The care assistants were responsible for housekeeping, laundry and kitchen duties and were also responsible for providing social activities in addition to their caring roles and responsibilities. The home did not have enough staff and the staff that were employed were not properly supported by means of training, supervision and appraisals. This was a breach of the regulations because provider of care services must make sure there are enough staff deployed to deliver the service and that staff are trained and supported to carry out their duties.

People were at risk because medicines were not always managed properly. This was a breach of the regulations.

The standards of cleanliness were poor and this was a breach of regulation because it meant people were living in a home which was not clean.

The hot water temperatures were not maintained within safe limits and there were no bath thermometers to check the temperature of the water before people got into the bath which meant people could be at risk of scalding. This was a breach of regulation because it put people who used the service at risk.

People told us they were satisfied with the food. However, we found the choice of food was limited and people's dietary needs and preferences were not always catered for. This was a breach of the regulations because the way people's dietary needs were catered for did not demonstrate regard to their well-being.

We were concerned at how people's weight and nutritional intake was monitored. This was a breach of regulation because it put people at risk of receiving unsafe care and treatment.

People who used the service and their relatives told us the staff were very caring and compassionate. During the inspection our observations supported this view. However, we found some working practices did not promote people's privacy and dignity. For example, people were limited in their choice of bathroom. This was because the home had a "bath person" who worked two days a week to support people with bathing and always used the same bathroom. This was a breach of the regulations because the provider's processes for monitoring the quality of the services provided had not identified this practice compromised people's privacy and dignity.

People's needs were not always assessed properly. People's care plans were not person centred and did not have enough information to guide staff on how to meet

Summary of findings

their individual needs and preferences. This was a breach of regulation because there was a risk people would not receive care which was appropriate, met their needs and reflected their preferences.

People told us they knew the manager and were able to make a complaint if they needed to. They said they didn't have any complaints. However, we found the complaints policy was not up to date and complaints were not always recorded and people were not always given feedback on the actions taken in response to their complaints. This was a breach of the regulations because the provider did not have proper systems for receiving and dealing with complaints.

Accurate and complete records were not maintained in respect of each person who used the service. For example, this was evident in people's care plans, risk assessments and the food and fluid charts.

The systems for monitoring, assessing and improving the quality of the services provided and for identifying and managing risks were not effective. This was a breach of the regulations because of the lack of good governance.

We found the provider was in breach of eight regulations in relation to safe care and treatment, person centred care, safeguarding, staffing, recruitment, premises, complaints and good governance. You can see the actions we have asked the provider to take at the back of the full version of the report.

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

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

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

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People living in the home and their relatives told us they felt safe. However, we identified a number of concerns which led us to conclude the service was not safe.

There were not always enough staff deployed and the recruitment processes were not robust which created a potential risk to people's safety.

Safeguarding concerns were not always identified and reported which meant there was a risk people were not adequately protected.

The home did not look or smell clean. The hot water temperatures were not managed properly which created a risk of scalding.

Medicines were not always managed safety.

Is the service effective?

Inadequate

The service was not effective.

People rights were not protected because the provider was not working in accordance with the Mental Capacity Act 2005. This was identified at the inspection in October 2014 and the provider had not taken suitable action to maintain compliance with the regulations.

People were not always cared for and supported by staff who were trained and supported to carry out their roles effectively.

People's dietary needs and preferences were not properly catered for.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were supported by staff who were caring and compassionate and knew about people's individual needs.

People's privacy and dignity was compromised by some working practices such as using people's bedrooms as a clinic for a visiting health care professional.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always assessed properly and people's care plans did not have enough information to make sure they consistently received care and treatment which met their needs and took account of their preferences.

Summary of findings

People were not supported to take part in a range of varied social and recreational activities.

The complaints procedure was not up to date and complaints were not always identified and deal with properly.

Is the service well-led?

Inadequate 

The service was not well led.

Accurate and complete records were not maintained in respect of the care and treatment provided to each person who used the service.

The quality assurance monitoring systems were not effective which meant people did not always receive the care and support they required.

Cliffe Vale Registered Care Home Limited

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.

The inspection took place on 21 October 2015 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case services for older people.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We contacted the local authority commissioners, the safeguarding team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We asked the provider to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people who used the service, six relatives and two health care professionals. We observed how people were cared for and supported in the communal living areas and observed the meal service at lunchtime. We looked at six people's care records, the medication records and staff files which included three recruitment files, supervision and appraisals records and training records. We looked at other records relating to the management of the service, for example, maintenance records. We spoke with the assistant manager, the senior support worker, three care assistants, the cook, and the maintenance person. We looked around the home at the communal living rooms, bathrooms and toilets and a selection of peoples bedrooms.

Inadequate

Is the service safe?

Our findings

All the people we spoke with said they felt safe and said staff looked after them very well. All the relatives we spoke with were happy with the service and the staff. We observed most staff knew people by name and that the people who lived in the home were relaxed and comfortable with the staff. One person who lived in the home told us, "I feel safe and happy, they are kind and we all get on." Another said, "I feel safe. We are looked after well and the girls are kind." We spoke with two relatives and they had no concerns about people's safety. One person said, 'It's ok – Mum is happy here and staff are good. Most of them have been here a long time. Mum falls a lot due to her illness – it's not neglect." Another said, "I know my Mum is well looked after. Mum is happy and she waves us off when we leave."

However, we found the provider did not have effective systems in place to ensure people who used the service were safeguarded from abuse. We found safeguarding incidents were not always recognised or reported to the local authority safeguarding team. On one staff member's supervision form we found information about an incident that had occurred in the home in August 2015 which described finding a person on the floor with a staff member by them shouting. We asked the assistant manager about this incident and whether it had been recorded as an incident and referred to safeguarding. The assistant manager said an incident form was not completed but the registered manager had spoken to both staff. They said they did not think the incident had been referred to safeguarding.

We found an accident report dated May 2015 in one care file which described how staff had found one person hitting and punching another person in their bedroom. There was no evidence to show that this incident had been referred to safeguarding and when we asked the assistant manager they said they did not know if it had been reported.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at three staff recruitment records and found shortfalls in the recruitment process. Application forms had been completed, yet two did not contain a full employment history. One form had no employment dates recorded and the other had no start date for one of the jobs listed. Although an interview form had been completed for one of these staff members, there was no evidence to show their employment history had been discussed. Two of the staff had only one written reference each and no evidence of any other references. The reference for one of these staff member's was from a friend and not their last employer who was on the application form. The third staff member had two references however one had not been fully completed and the referee had asked to be contacted. We asked the assistant manager if this had been followed up and they said they did not know. All three staff had criminal record checks completed before they started work. We looked at the recruitment checks for a volunteer who worked in the home which consisted of a criminal record check and copies of proof of identity. We looked at the recruitment policy which made no reference to volunteers.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The assistant manager told us there were 25 people living in the home and the usual staffing levels were four care staff on duty between 8am and 1pm, three staff from 1pm until 10pm and two staff from 10pm until 8am. They said a senior care assistant usually worked most nights but if there was no senior on duty care staff had to ring the staff member on call if anyone required any medicines. The assistant manager said one of the care staff had recently started at 7am instead of 8am to increase the staffing levels at a 'busy time'. They said they were trialling this for a couple of months. The assistant manager told us an additional care staff member worked 9.30am until 3pm two days a week and their task was to bath people. One person who used the service told us they often had to wait for staff to help them; they said they felt "dumped" in the lounge because they could not move without help from staff. We observed they were not able to reach to call bell from where they were sitting and had to wait for staff to come into the lounge to get the help they needed. The same person told us on the previous evening staff had wheeled them to the front door so that they could smoke a cigarette. They said they had to wait an hour, in the cold, for staff to help them back into the home.

Inadequate

Is the service safe?

There were no cleaning or laundry staff employed. The assistant manager told us these tasks were completed by the care staff. We spoke with one of the night staff who told us they did cleaning, laundry and ironing overnight in between two hourly checks on people living in the home.

The provider engaged the services of an activities coordinator who carried out two one hour sessions each week. Outside of these two hours care staff were responsible for organising activities. Two people's relatives told us the thought this was not enough and more activities were needed. One relative said, "More activity is needed, there is some but it's not enough."

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

We looked round the home and found standards of cleanliness were poor. The majority of bedroom carpets were covered in bits and required hoovering. There was a strong odour of urine in three bedrooms. In one of these bedrooms the smell was overwhelming and we alerted the assistant manager who arranged for the carpet to be cleaned straightaway. We found brown stains on the bedding in three rooms although the beds had been made. In one of the bathrooms the bath and toilet were dirty and there was hair in the bath mat. We saw cleaning charts in bathrooms, toilets and people's bedrooms but the majority of these had not been completed since 19 October 2015. The assistant manager told us there were no cleaning staff employed and said they were advertising for domestics. They said care staff were working extra hours to cover the cleaning tasks in addition to the care hours they worked.

We observed that rooms and hallways were cluttered with wheelchairs and walking aids and other equipment, which were potential hazards. In one of the lounges the call bell was out of reach for most people.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked the hot water temperature at some of the sinks and baths and found the water was so hot we could not keep our hand under the flow. We looked at the records of water temperature checks carried out by the maintenance person and saw temperatures regularly exceeded 44 degrees centigrade. This is the maximum temperature recommended by the Health and Safety Executive where outlets are accessible to vulnerable people. We spoke with the maintenance person who said they were not sure what the correct temperature should be but thought it was about 50 degrees centigrade. We went with them to test the hot water in the ground floor bathroom; the temperature probe used by the maintenance person registered 56.9 degrees centigrade. There were no thermometers in the bathroom for staff to check the water temperatures. When we asked one staff member how they carried out these checks they said they knew how people liked their baths and asked them to 'dip their toe in' to check if it was all right.

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

We found up-to-date safety certificates were in place for the chair lifts and hoists, as well as gas safety, fire safety equipment and electrical hard wiring.

We observed a senior care worker administering the morning medicines to people who used the service. They had a good understanding of people's medicines and were kind and patient, explaining to people what their medicines were for and encouraging people to take them. Some medicines had special instructions about how they should be given in relation to food and we observed there were suitable arrangements in place to make sure this happened.

We saw three people were prescribed a medicine which is used to regulate heartbeat. The dispensing directions stated the medicines should not be given if the persons pulse rate was 60 or below. We found staff were not checking the person's pulse rate before they administered the medicines. We asked the senior care worker who was giving the medicines about this. They said they were not trained to check people's pulse rate. They said the district nurses checked people's pulse rate periodically but not every day.

We saw medicines which required refrigeration were kept in plastic container in the fridge in the kitchen. Neither the container nor the fridge was locked and the kitchen door was unlocked most of the time. This meant the medicines were not secure. We saw medicines stored as controlled

Inadequate

Is the service safe?

drugs were kept in a small safe in a metal cabinet. While this was secure and access to the code was restricted to designated staff it did not comply with the legal requirements for the storage of controlled drugs.

The assistant manager told us there were some nights when the home did not have a senior care worker on duty therefore there was no one trained to give out medicines. They told us there was a member of senior staff on call who would come in if necessary to administer medicines. We asked one of the senior care workers where the medicine keys were kept when this happened. They told us they were kept in an unlocked cupboard in the dining room. This meant they were not secure.

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

The medication administration records (MARs) were up to date and people's medicine allergies were recorded. Records were kept for medicines received and disposed of. Some medicines such as eye drops had an expiry date linked to the date of opening. We saw the date of opening was recorded and the medicines in use had not expired.

None of the people living in the home at the time of the inspection were administering their own medicines. The senior care worker told us none of the people living in the home were being given medicines covertly, (in a disguised or hidden way). The senior care worker told us when people were prescribed insulin the district nurses visited to check people's blood sugar levels and give the insulin.

Inadequate

Is the service effective?

Our findings

The assistant manager told us staff received supervision every three months but acknowledged that these had slipped this year. We looked at two staff files which reflected this. One file showed the staff member had received three supervisions in 2013, one in 2014 and one in 2015. The other file showed three supervisions in 2013, none in 2014 and one in 2015. The home's supervision policy stated all staff would receive one hour of formal supervision every two months.

The provider told us in the PIR (Provider Information Return) that no staff appraisals had been done in the last 12 months. This was confirmed by the assistant manager during the inspection. The home's training policy stated all staff should receive an annual appraisal.

One of the night staff we spoke with told us they had attended an afternoon of induction training and then gone directly onto nights as one of the two staff on duty. They told us they had not received any moving and handling training when they started work at Cliffe Vale; their last moving and handling training had been over three years ago with a previous employer. This was confirmed by the training records. We asked the assistant manager about this and they confirmed this member of staff had not received training on moving and handling people but added it was booked for 19 November 2015.

The provider told us in the PIR that none of the staff had received training on safeguarding adults, first aid or emergency aid. This was confirmed by the training records we looked at during the inspection, we found no record of training on first aid or emergency aid and the last safeguarding training we could find was in 2012.

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

We met with the cook who told us they worked five days a week 8am to 2pm. The cook showed us the menus which followed a four week rota. They told us there was a choice of cereals and toast for breakfast, we asked if people could have a cooked breakfast and were told no because it wasn't on the menu. One meal was served at lunchtime. We asked the cook if any alternatives were offered and they said no, although people could have a sandwich instead if they wanted. They told us there were no special diets, just three people who were diabetics. We asked the cook if anyone was nutritionally at risk and needed their food fortifying or extra calories. They told us there were a couple of people who had Complan but did not know of anyone else and said they added cream to mashed potatoes. We asked if snacks were provided to people and the cook told us tea, coffee, juice and biscuits were provided mid-morning and mid-afternoon. They said they did not know what was provided at supper time as this was left to the care staff. We asked if there was any home baking and the cook said they sometimes made a sponge for dessert but did not routinely do any baking. We asked if soups were homemade and the cook said they were either made from powder or came from a tin.

At lunch time we observed there was no alternative main course available, although we saw two people who were poor eaters were offered sandwiches. We saw one couple refused to eat what was on offer and they were not offered anything else. Dessert was also set down without any explanation but we did see one carer providing 'diabetic' desserts to 3 people.

This was a breach of Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The meal served at lunchtime looked hot and fresh and the people we spoke with seemed satisfied. One person said, "The food is perfect, I've no complaints." A relative told us, 'My relative is used to different foods and if I bring them in the staff microwave them for her".

We were concerned at how people's weight and nutritional intake was monitored. We looked at the weight records for one person which showed they had lost 4kgs between March and September 2015. The malnutrition universal screening tool (MUST) assessment had been completed on 01 September 2015 and assessed the person as medium risk. However, the weight charts showed this person had lost a further 5kgs between 01 September and 02 October 2015 and the MUST assessment had not been reviewed.

Their nutritional care plan dated 08 October 2015 stated to add extra protein to meals, offer snacks between meals and give Complan daily. A review on 14 October 2015 stated to record a daily food chart, weigh every two weeks and ask the GP to increase Complan to twice a day. There was no evidence to show the person had been weighed since 02 October 2015. We looked at the food charts for this person.

Inadequate

Is the service effective?

The last chart completed was dated 19 October 2015 and recorded only breakfast and mid-morning coffee and biscuits as the intake for the whole day. The food chart for 16 October 2015 was blank and the one for 15 October 2015 recorded no input until mid-afternoon. We looked at the person's medication records and saw the Complan had not been increased; they were still having Complan once a day.

Another person's nutritional care plan was dated 23 January 2014 and identified weight loss and gave instructions on the type of food and snacks to be offered and to call the dietician if needed. The last review of the care plan was on 22 March 2015 which stated 'updated and reviewed'. The weight records showed they had lost over 3kgs since this review yet there was no evidence to show any action had been taken to raise this with healthcare professionals or the dietician.

Another person's records showed they had lost 6.7kg between November 2014 (64.1kg) and October 2015 (57.4kg). The care plan dated 22 July 2015 stated the person's weight should be monitored two weekly however this was not being done. Their weight had been checked twice in August, once in September and again on 02 October 2015. A nutritional assessment had been done on 01 September 2015 which identified the person as "low risk" although they continued to lose weight. The care plan had been reviewed on 14 October 2015 and the review stated "no changes" were required despite the weight records showing the person had continued to lose weight. We looked at the person's food charts; the chart for 13 October 2015 had only one entry which stated they had refused lunch. The chart for 14 October 2015 had one entry which stated the person had Ensure mid-morning. The chart for 17 October 2015 had nothing recorded for lunch or supper time.

This demonstrated the provider was not assessing and mitigating risks to people's health and safety which meant people were at risk of not receiving safe care and treatment.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The assistant manager told us one person had a deprivation of liberty safeguard (DoLS) authorisation in place. However, when we looked at the documentation we found an urgent DoLS authorisation had been approved but had expired in February 2015. We saw an application had been made for a standard authorisation in February 2015 but there was no evidence to show this had been granted. When we asked the assistant manager they said they did not know if the authorisation had been approved.

We found staff lacked knowledge and understanding of the legal framework of the Mental Capacity Act 2005 (MCA) and DoLS. We observed one person with dementia who was distressed and repeatedly asking to go home, saying "I don't know why I'm here. Why am I here?" Although staff were kind and patient with the person offering constant comfort and reassurance, the assistant manager had not considered an urgent DoLS application was necessary until we raised this with them.

At the last inspection in October 2014 we found the provider did not have suitable arrangements in place to make sure the service was operating in accordance with requirements of the Mental Capacity Act 2005. During this inspection we found the provider had not taken suitable actions and continued to be in breach of the regulations.

This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service effective?

People had access to NHS service, district nurses and GPs visited people in the home. We asked one of the senior care workers about access to dieticians and/or speech and language therapists and they told us this was done via the GP.

We spoke with a visiting health care professional who said, "This is one of the better homes I visit and people are looked after well. The staff are fantastic."

Requires improvement

Is the service caring?

Our findings

People living in the home and their relatives were all very complimentary about the care given by staff and during the inspection we observed staff were very caring and compassionate and knew all the people who lived in the home by name.

One person's relatives told us, 'We are always made to feel welcome and they recognise us." Another relative said, "We can visit whenever and are always made welcome." These comments were echoed by other people's relatives and one person we spoke with described Cliffe Vale as a "homely" place.

People's relatives told us they were kept informed and involved. One person told us they had expressed concerns about the number of falls their relative was having. They said, "The manager called a meeting and gave me reassurance that the falls were due to illness and offered advice and tips how to avoid them in the future."

Another relative told us, "'I come in to feed her but if I didn't they would do it. They have put a mat beside her bed that tells them if she gets out. I'm involved in her care plans and communication is good. They are nice people – book me in when it's my turn."

We observed the meal service at lunch time. The tables were set with just one spoon and a napkin per person, with a glass of orange juice. There was no menu and people were not told what was for lunch. When everyone was seated, bowls were put down on the table with little interaction from staff. Bread was offered but there was no side plate on which to put it.

After lunch people were helped back into the lounges but hot drinks were only prepared once the dining room tables had been cleaned and wiped. We heard one person say, "I'd like a cup of tea' and they were told they would have to wait.

During the inspection we observed the men were clean shaven. We observed the home had a number of bathrooms which were bright and airy but found that only one bathroom was used regularly. This was because the home had a dedicated 'bath person' who worked two days a week and always used the ground floor bathroom. We asked if this arrangement meant people could only have a bath on these days and were told that was not the case.

The optician was visiting during our inspection. We saw they had set up their equipment in a person's bedroom with items laid out on the bed and furniture. They told us they carried out eye tests in this room for different people and we saw people going into the bedroom for tests. Using this person's bedroom as an eye clinic showed a lack of respect and compromised their privacy and dignity.

The provider's processes for monitoring and assessing the quality of the services provided had not identified these areas of practice which compromised people's privacy and dignity.

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

Inadequate

Is the service responsive?

Our findings

We looked at the care records for a person who had recently been admitted to the home. There was no pre-admission assessment recorded and when we asked the assistant manager about this they said the person had visited the home for a few hours the week before they were admitted but acknowledged there was no record of an assessment to determine if the home could meet the person's needs. We were concerned about the lack of information available about this person and the circumstances surrounding their admission to the home, which we discussed with the deputy manager.

We found care records provided limited information about people's needs and preferences and the support required from staff. For example, one person's care plan for continence recorded the need as 'slight accidents' and the action was 'wears pads, needs reminding to change' the care plan was dated 7 January 2010 and had last been reviewed in November 2010.

Another person had a continence care plan dated 27 April 2010. It had been updated on 12 January 2012 and stated the person should be supported to use the toilet at 11am, 2pm, 4.30pm and as needed. The most recent review was dated 17 February 2015 and stated the person should be assisted to use the toilet "more regularly".

A further person had only three care plans for eating & drinking, continence and mobility. The eating and drinking care plan was dated 12 November 2014 and had not been reviewed since. The continence care plan had the same date and had been reviewed once in August 2015 where it stated 'no change'. This person was living with dementia but there were no care plans to show how staff should support this person in relation to their dementia.

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

In one person's records we saw the falls risk assessment was blank, although an accident report showed the person had fallen in June 2015 and sustained a skin tear.

Another person's care records showed they had sustained three falls between 18 September and 19 October 2015. The falls risk assessment had been completed on 29 September 2015 and assessed the risk as very high, yet the care plan for falls was dated 28 March 2014 and made no reference to these falls or gave any guidance as to how the risk could be reduced.

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

Many of the relatives we spoke with told us they were felt involved in their relatives care. However, in the care records we looked at there was no evidence to show people or their representatives had been involved in drawing up the care plans or making decisions about their care.

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

In both the lounge areas we observed people listening to music which was playing quietly. There were televisions in both lounge areas but they were not switched on during the day. Throughout the morning the home was busy with lots of visitors.

We saw an activity rota which advertised activities for two hours each week. Two people we spoke with said more activities were needed. One said, "More entertainment is needed. They had a band on last month and it was very good and I've seen them doing reminiscences but they need to do more. They have parties at Christmas and trim up. When there is entertainment on they get a glass of sherry.' Another said, "More activity is needed, there is some but it's not enough."

The home had a complaints policy which required updating as it referred to the National Minimum Standards which was part of legislation which is no longer in force. At the last inspection in October 2014 we told the provider the complaints procedure needed to be updated.

We looked at the complaints records which showed two complaints had been received since the last inspection in October 2014. One complaint was received in January 2015 and recorded the detail of the initial complaint, the investigation and how the outcome of the complaint had been fed back to the complainant. The second complaint received in May 2015 contained details of the complaint, discussions with staff and outlined points to be included in

Inadequate

Is the service responsive?

the response. However, there was no evidence to show what feedback had been provided to the complainant. We asked the assistant manager about this and they said they did not know.

We saw minutes from a senior staff meeting held in July 2015 which made reference to complaints received from people who used the service and relatives about aspects of care. We asked the assistant manager where these complaints were recorded and what action had been taken. They said they did not know.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The people we spoke with told us knew the manager and were aware of how to make a complaint if they needed to. They said they didn't have any complaints.

Inadequate

Is the service well-led?

Our findings

We saw surveys completed by nine relatives in September 2015, all of which provided positive feedback about the service. Comments made about the care their relative received included 'very happy and settled at Cliffe Vale' and 'so happy and well looked after'. Two people's relatives told us they had been sent a satisfaction questionnaire during the year, which they appreciated.

All the people we spoke with told us there hadn't been any meetings for people who lived in the home or their relatives. This was confirmed by the assistant manager. The assistant manager told us discussions were held with people who used the service on a one-to-one basis. When we asked where these discussions would be recorded the assistant manager said they were not recorded.

The assistant manager told us there were regular senior staff meetings but no meetings were held with the rest of the staff. We asked how information was shared with other staff and the assistant manager said the registered manager sent memos to the care staff.

We reviewed some of the policies and procedures relating to recruitment, training, supervision, safeguarding and complaints. The dates on the policies ranged from 2007 to 2010. Although there was a list which stated all the policies had been reviewed in January 2015 we found the guidance some of the policies referred to was out of date, for example the National Minimum Standards.

We found the provider did not have effective processes in place to assess, monitor and mitigate risks relating to the health, welfare and safety of people who used the service and others. For example, there was no process in place to carry out an overall analysis of accidents and incidents to look for trends and patterns. This meant the provider was missing an opportunity to identify, assess and mitigate potential risks. We discussed this with the registered manager at the last inspection in October 2014. The assistant manager told us there was no risk assessment in place for the stair lifts which were the only means of access to the first and second floor, the home did not have a passenger lift.

The providers processes for checking the premises had not identified the potential risk of scalding arising from the fact the hot water temperatures were not being maintained within the recommended safe temperature range.

We found the provider did not have effective systems and processes in place to assess, monitor and improve the quality of the services provided.

At the last inspection in October 2014 we issued two compliance actions for breaches of regulation. The breaches were as a result of failings in relation to meeting the requirements of the Mental Capacity Act and assessing and monitoring the quality of the services provided. During this inspection we found the provider had not taken action to ensure on-going compliance with the regulations. Of particular concern was the fact that we had to ask the assistant manager to make an urgent application for an authorisation under the Deprivation of Liberty Safeguards as detailed in the effective section of this report.

In addition, we found shortfalls across all aspects of the service which the provider's processes for assessing and monitoring the quality of the services provided had not identified as concerns and/or areas for improvement. These included shortfalls in the care, support and treatment provided to people who used the service, the safety of the environment and the numbers and skills of the staff available to support people.

We found shortfalls in people's care records, including care plans, risk assessments and food and fluid charts which demonstrated accurate and complete records were not maintained in respect of each person who used the service.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 9 (1) (3) (b) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way in relation to the proper and safe management of medicines. Service users were at risk of receiving care and treatment which was not safe because the provider was assessing risks to people's health and safety and was not doing all that was reasonably practicable to mitigate any such risks. Regulation 12 (1) (2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Effective systems and processes were not in place to ensure people who used the service were protected from abuse. Suitable arrangements were not in place to make sure service users were not deprived of their liberty unlawfully. Regulation 13(1)(2)(5)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The home was not clean. Regulation 15(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints An accessible system was not established or operated for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed. Staff did not receive appropriate support, training, professional development and appraisal to enable them to carry out the duties they were employed to perform. Regulation 18(1)(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Effective recruitment procedures were not in place to ensure staff employed were of good character and had the necessary qualifications, competence, skills and experience to carry out the role for which they were being employed. Regulation 19(1)(2)