Equality Care Limited

Longbridge Deverill House and Nursing Home

Inspection report

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Date of inspection visit:
09 January 2017
11 January 2017

Date of publication:
19 May 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Longbridge Deverill House and nursing home are two separate buildings set on one site and overall are registered as one service to provide either personal care or nursing care for up to 80 people.

Longbridge Deverill House is an older style property and offers accommodation and personal care. At the time of our inspection there were 17 people living at Longbridge Deverill House. Directly behind the house is another newer building which provides accommodation for people who require personal and nursing care. The nursing home is divided into four units which support people with varying levels of health needs. There were 56 people living in the nursing home at the time of the inspection. The service did not have a registered manager in place, however a new manager had started in November 2016. The manager was intending to register with CQC.

We looked at the concerns raised and found the provider had not protected people from the risk of harm and abuse as some people were being unlawfully restrained as a means of managing their behaviour.

There were systems in place to ensure that medicines were administered safely and people received their medicine on time and in a place of their choosing. Stock levels were correct and disposal of medicine were managed in line with the provider policy.

People and their families told us staff were kind, considerate and caring. However, due to the concerns we found around restraint we did not find this to always be the case. We observed people had developed positive relationships with staff and people told us they felt safe.

There was a lack of equipment to ensure safe infection control practices could be followed. Not all areas of the environment or premises were safe and suitable for the intended use.

Staffing levels were not determined by the needs of people which resulted in people not always receiving timely and appropriate care and support. People told us they liked the staff.

There was a varied range of nutritious food available and people told us they enjoyed their meals and had sufficient to eat. Within some units of the nursing home we found the meal times were not organised enough to ensure people received appropriate support.

Staff supervision was not routinely being carried out and appraisals had fallen behind. Staff told us the training they received was good, however a course intended to enable staff to help people manage their behaviours was not appropriate. This led to a culture of staff perceiving it was in the best interests of people to restrain them when they became agitated. We found the lawful process intended to protect people from abuse had not been followed.

There were varying levels of understanding from staff around the Mental Capacity Act 2005 and the provider

had failed to ensure that due process was followed in line with the Act.

People had access to a range of activities and social interaction however some people did not receive appropriate stimulation, social interaction and meaningful occupation if they did not wish to participate in the activities on offer.

Care plans were not person centred and lacked information about how to enable and support people with maintaining daily living skills and their independence. Care records were inconsistently completed between different areas of the service and lacked detail about people's care and support. Care plans had not been effectively reviewed to ensure their current needs and preferences were known. The monitoring of people's care and support was inconsistent.

Quality assurance systems, governance and the audits in place had identified some of the concerns we found, however remedial action had not been taken to address the shortfall. Other concerns we raised were not identified by the quality assurance systems in place.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were being restrained and this was not a proportionate response. The process was not lawful.

People's medicines were administered safely and people received their them on time and in a place of their choosing.

Staffing levels were not set according to people's needs.

The premises were not fully safe.

Is the service effective?

Inadequate

The service was not effective.

Staff had not routinely received supervision and appraisals had fallen behind.

People's rights were not protected as the service failed to adhered to the principles of the Mental Capacity Act 2005.

People told us they enjoyed the food and we saw there was a varied and nutritious diet.

People received the support of health professionals when required although referrals were not routinely made to the speech and language therapy department.

Is the service caring?

Requires Improvement

The service was not always caring.

End of life care plans were not person centred as they lacked information about people's preferences and wishes during that time.

People were not always treated with dignity, for example in supporting people to maintain their personal hygiene. People told us they liked the staff and relatives told us they were happy with the care their loved one received

We observed for the most part that staff interacted with people in a kind and considerate manner. This approach enabled staff to develop positive relationships with people.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive safe care and support.

People did not receive a consistent level of support with regard to meaningful occupation and activity across the service. Care and support plans had not been updated to reflect the person's current needs and preferences.

People told us they would talk with the staff if they had any complaints and relatives and people told us they were happy with the service.

Is the service well-led?

Inadequate

The service was not well led.

Audits in place did not identify the shortfalls we found and timely action had not been taken in response where the service had identified shortfalls.

A recent survey had been sent out to ask families for their views on the quality of the service being delivered.

There was a lack of leadership within the nursing home which affected how the service was delivered.

People and relatives spoke highly of the staff and felt the home was well managed.

Longbridge Deverill House and Nursing Home

Detailed findings

Background to this inspection

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

Prior to the inspection we received information of concern around people being restrained without the lawful authority being in place. During this inspection we found this to be the case. We carried out an unannounced inspection on the 09 January and completed the inspection on the 10 and 11 January 2017. The inspection was carried out by two inspectors and two experts 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.

We spoke with 28 people across Longbridge Deverill residential home and the nursing home. We spoke with nine relatives about their views on the quality of the care and support being provided. We spoke with the provider and the manager and excluding these spoke with a total of 31 staff. This included the deputy manager, nursing staff and unit leads, senior and other care workers, agency staff, activity co-ordinators, the hairdresser, housekeeping and maintenance staff. We looked at 23 care records. We also reviewed documentation in relation to the management of the home. This included staff training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Requires Improvement

Is the service safe?

Our findings

The provider failed to ensure that people were protected from abuse and improper treatment. Prior to the inspection we received information of concern relating to the unlawful use of restraint on people. During the inspection we found this to be the case and as a result of our findings we made safeguarding referrals to the relevant authorities for people subject to restraint.

Staff were carrying out acts intended to control or restrain people that were not necessary and not a proportionate response to the risk of harm presented. Staff were restraining people both psychologically and physically for example, in one person's care records the guidance for staff was to remove the person's walking stick when they became overly agitated rather than through positive changes to the person's care and support. Staff were holding people to move them or blocking their movements and care plans did not document alternative options as the least restrictive practice.

People were not supported to take positive risks which would increase their wellbeing as well as reducing reliance on restraint to maintain their safety. For example, staff told of one person who loved to play football in the hallway, however, the person did not do this anymore, as the registered manager at the time felt it was a risk to other people. Staff told us it was managed really well, gave the person pleasure and did not feel it was a risk.

People were being restrained by staff as way of managing behaviours and staff confirmed this was the practice. One person who shouted and verbalised loudly had their room door shut so that other people could not hear them. This response was in their care plan as guidance to staff and there was no recognition that this practice was not appropriate.

The lawful process of applying for and being granted a Deprivation of Liberty Safeguard (DoLS) for such restraints had not been carried out. In people's care records we saw staff had been given guidance to use restraint where it was not required. Where people had a behavioural 'risk/crisis management plan' in place, these were not being followed by staff and were not effective as people continued to exhibit the same behaviours and anxieties. A member of staff looked at one care plan and told us "No, absolutely not, this person has no need to have this in their care plan".

Risks management systems did not protect people from harm because of a lack of monitoring and detailed guidance to staff. Records demonstrated staff were not always monitoring the whereabouts of people as detailed in the care plans. There was lack of descriptive guidance in these documents such as 'use friendly expressions and non-verbal communication' without saying what that meant. However it was noted that staff do receive training on dementia care, communication and non-verbal communication

In the care plans we looked at, they were similar in content and not specific to the person and their individual needs. The care plans and assessments did not say how the person communicated and what that communication meant; rather it described 'difficulties with communication'.

During the inspection we saw staff running when they heard raised voices, this did not promote a person centred and calm approach to supporting people when agitated or distressed. Daily recording of incidents were not descriptive for example; people were described as being 'very violent', aggressive' and 'vocal today'. There were no clear descriptors of this behaviour within the care plans we reviewed and therefore the interpretation of behaviour was dependent upon how individual staff perceived the behaviour. This led to a lack of a co-ordinated and consistent approach to supporting people with behaviours which may challenge.

Not all support plans were person centred as they did not recognise the behaviour was a result of the person's condition and did not fully address how the person could be supported when frustrated. However some support plans did contain this information.

We observed that people exhibited signs of frustration such as, hitting objects, overturning chairs, repeating phrases, wandering or asking questions repeatedly. In addition, people were not supported to take part in meaningful activity to help reduce frustrations that may lead to behaviour that challenges.

All but one member of staff had received training in the safeguarding of vulnerable adults. In the nursing home we found not all staff, which included agency staff were confident in explaining the different types of abuse and the expectations placed on them when abuse was suspected. We saw two people in the nursing home who had extensive bruising on the back of their hands and forearms, another person had bruising to their chest. Staff were not always assessing these injuries and had not considered bruising a concern of potential abuse as some incidents had not been recorded and followed up. Staff, including agency workers were not suitably skilled or competent in the safe and appropriate management of behaviour.

We spoke with a senior member of staff who disregarded the views of one person and took a defensive approach when accusations were made against the staff. One person had made allegations of abuse. The senior member of staff did not make a referral to the appropriate safeguarding team or carry out an investigation. They stated to us "some people make allegations, I know my staff, it would be unlikely". This demonstrated a lack of understanding around their responsibilities to safeguard and protect people from the potential of harm.

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

Following the inspection the provider wrote to us with the immediate actions they had taken to ensure people's safety. Training had been arranged for all staff in positive behaviour support. Behaviour support plans had been reviewed and rewritten to use the least restrictive intervention. The provider had sought the support of external agencies such as the mental health team, the care home liaison team and the DoLS (Deprivation of Safeguards) team in addition to attending safeguarding meetings. The provider and manager had met will all staff to give firm guidance on not using any type of restraint.

The provider did not have a system in place to calculate the number of staff hours required according to people's needs. They therefore could not be assured that staffing levels were appropriate and safe. A relative said how they had to go and find a member of staff to help a person in another room. Another relative told us "there are never enough staff". Some people were able to tell us they "had to wait for staff". Staff told us "some days there are enough skilled staff but some staff don't have the basic skills and when we have new agency staff we struggle". We observed times where staff were not visible or available to people, such as vulnerable people being left unattended in the lounges, people waiting to receive care and support and in particular the deployment of staff at meal times. For example, whilst people were left unattended in the

lounge, they asked members of the inspection team for support. One person waited 45 minutes for their lunch as staff arranged the meal time and whilst people were sat at a table together, they did not receive their meal together.

The manager had recently recruited eight new members of care staff and we met with them as they undertook their induction. In the interim, the service was using agency care workers.. During the week of the inspection, there was on average 49 percent of staff who were agency workers against the number of permanent staff on duty.

For some agency staff there was a lack of understanding around safeguarding people, the Mental Capacity Act 2005 and DoLS and awareness of dementia care. Due to the high level of support some people required around managing their emotional wellbeing and mental health, agency workers were having to step in to de-escalate unsafe situations. An agency worker told us they "gently had to restrain a person by holding their arm around the person and walking them to another area". They were not able to describe restraint to us and told us they had not received any training around techniques or how to manage behaviours.

The systems in place to manage risk were not consistently followed by staff. This related to the nursing home. Monitoring charts used to assess people's nutritional and fluid intake were not being fully recorded or totalled at the end of the day. This meant staff did not have access to accurate information and in particular when nutritional or fluid intake was poor. People's weights were not being accurately recorded with sometimes large variances such as for one person a six kilogram loss and for another person a five kilogram gain in one month. This had not always been investigated to check the accuracy of the weight or followed up with involvement from relevant health professionals, and a review of the support plan.

Repositioning charts did not identify how staff had repositioned the person and could therefore not be assured that safe and effective care was being delivered. During the inspection, the manager amended the charts to identify if the person had been moved onto their left or right side or their back. The previous charts demonstrated people were not being repositioned as required to relieve pressure from specific points of their body.

For two people who had pressure ulcers, we were unable to ascertain if they had received care in line with their support plan. For one person the wound evaluation care plan stated the dressing should be changed on alternate days. The personal care action plan stated the dressing should be changed every three to four days. The personal care plan had not been updated to reflect the need for the dressing to be changed more frequently. In addition, there was no recording of when the dressing had been changed. We discussed this with the unit lead, who stated they had seen the pressure sore on the 10 January 2017 and there was no dressing on the wound as it was 'almost healed'.

For another person there was a discrepancy in the wound evaluation care plan and the personal care plan because the documents had not been updated following guidance from the tissue viability nurse. A lack of robust care planning could result in people not receiving the care and support they require.

On two of the nursing units there were a high number of people who were having a soft or pureed diet, with supplements due to the risk of choking and risk of malnutrition. There was a lack of information as to the initial assessment and rationale as to why a person would be at risk of choking. We spoke with the head of the SALT team (Speech and Language Therapy) who told us nursing staff at the home would contact them for advise on the support needs of people at risk of choking. However, this was advise and they expected referrals to be made to their team if an assessment was required. People received either a soft or pureed diet or a normal diet. We found no information which considered different types of textured diet which people

could safely tolerate and which linked to the level of risk of the person choking. Out of 15 people who were deemed at risk of choking, we found two assessments had been completed by the SALT team and for other people, staff had made the decision to put them on a soft diet. Staff had not ensured that referrals were made to the speech and language therapy department when required.

People did not always receive safe care and treatment and steps were not taken to mitigate the risks. One person had the head of their bed in a high position with a bed rail in place to protect them from potentially falling out. Staff recorded "the bed rail was left down and as X is unable to use the controls for the bed rail, this must have been left down by staff". This was noted by staff however it was not followed up as to why this had occurred or additional checks put in place to ensure it did not happen again.

In the residential home, the room used to store medicines was not clean and posed a risk of infection. The linoleum was cracked in three places which could lead to bacteria forming in the cracks due to dust and dirt. The wall behind the main sink was not clean and items were stored on the floor gathering dust. The fridge used to store medicine was not fully accessible as the pipe work from the hand sink prevented the door from opening fully. This meant the fridge could not be cleaned adequately to ensure it remained hygienic. The enamel on the main sink plug had worn away and the hand sink had a residue of lime scale on it. Damaged surfaces may harbour micro-organisms which would increase the risk of infection and cross contamination from the sinks to hands. The carpet in the main office which people accessed was heavily stained and not clean.

Some areas of the residential home required more intense cleaning such as the windowsills and skirting boards in the lounge and along the conservatory walkway. However, due to paint flaking it would be a difficult task to clean thoroughly.

In the Wylye and Marques units of the nursing home there was a strong odour of urine throughout. The seat covers of easy chairs which people used, although had been washed were stained. The arms of sofa's and other easy chairs were not clean. Throughout the nursing home there was a lack of pedal bins in the communal toilets and bathrooms. This could increase the risk of infection through clean hands touching the lid of the bin to lift it.

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

Following the inspection the provider contacted us with the actions they had taken to reduce the potential risks to people. The medicine room had been completely redecorated with a new sink. The cleaning of the home had been reviewed with changes to the current contract. Support plans had been rewritten and were being closely monitored and checked by senior staff. New staff were now in post and the use of agency staff had reduced significantly.

The pathway from the residential house to the nursing home was not safe. It had not been maintained, as midway up the path was a step and an upwards slope which was covered in gravel. Walking over the step and straight onto the gravel was slippery and unstable. This meant that people and visitors would need to walk on the private driveway for that part of the pathway where cars were parked alongside. There is a pavement for most of the way although not all of the way due to access requirements for vehicles.

In the small dining room in the residential home, the edging strip to a corner unit was missing which posed the risk of injury particularly to people who have frail skin. The general maintenance of the home had not been kept up as skirting boards, doors and surrounds had paint flaking which would make it difficult to keep

clean. During the inspection we saw the door to the basement was open. This had steep steps going down and did not have a sign to make people aware of this, especially for people with dementia. This therefore posed a risk to people of injury from a fall.

During the inspection we were able to access a cupboard in the nursing home as it was not locked. The cupboard was directly off of the hallway and housed the electrical wiring. The premises had not been made secure to minimise the risk of people unintentionally touching or pulling on the electrical wires with the potential of causing themselves harm.

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

People told us they felt safe and where people were not able to verbalise their opinion, we observed they were comfortable in the company of staff. Relatives told us they felt their loved one was safe and comments included "yes, definitely safe here, she has a safe bed and has established a relationship with staff" and "I am very happy all round".

Medicines were administered safely and people received their medicines on time. There were protocols in place for medicines which were prescribed as PRN (as and when required) and staff received appropriate training and assessment to ensure they were safe and competent to administer medicines. Safe storage and disposal of medicines were in line with the provider policy and procedures.

We reviewed six staff files which evidenced that safe recruitment practices were followed. Personal emergency evacuation plans were in place and described the person's medical condition and the support the person needed by staff to safely evacuate the premises in the event of an emergency.

Inadequate

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Not all staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and as a result staff had varying levels of understanding about the Act, the principles behind the Act and the legal process. Staff had access to a key card which they showed to us and which contained the key principles of the MCA. They told us the cards were useful as it gave them a reminder. On a day to day basis people told us staff supported them to make decisions, such as what to wear, how they would like to spend their time and with meal selection.

The administrator provided us with a list of people where their representative had either applied for a lasting power of attorney (LPA) or had been granted one. This was in relation to decision making about either financial matters or health and welfare purposes. This information was recorded at the beginning of each care plan. However, this information had not been included or cross-reference to relevant places within the care plan. This meant that if staff did not review the relevant page, they may not be aware that decisions made on behalf of the person by a representative were lawful. For example, in four care plans we saw either family were making complex decisions on behalf of their loved one without an LPA having been applied for, or instructions that the family and carers would make important decisions and where the lawful authority had not been granted. This meant that people's rights were not being protected as the law intended.

We reviewed care records within the nursing home and found a standard letter had been inserted into people's records. The letter was from a local GP surgery entitled 'Management of the choking resident' and which included instructions to staff. It stated "if a patient choked it is acceptable (and would be expected) that nursing home staff perform first aid. If this process fails and the patient becomes unconscious then Cardiopulmonary Resuscitation (CPR) should not be attempted." The unit lead told us these forms were used for all of the people in the home. These instructions did not consider if the person had an advanced directive, wanted CPR to be performed and was not part of any treatment escalation plan, or which involved the person or their legal representative in this decision. We discussed this with the manager who told us they would immediately withdraw this document. However the use of this form demonstrated a lack of understanding around promoting people's rights. During the inspection the manager started to remove this from people's records and following the inspection informed us this had now been done for each person.

Mental Capacity assessments had either not been completed or due process had not been followed. In all of

the MCA assessments we reviewed, there was a lack of information which demonstrated how staff had sought to involve the person in the decision being made. This meant the provider could not be assured that due process was followed before a best interest meeting took place. We did not see a robust framework in place where best interests meetings were held, with a rationale for the decision being made, where the person was involved and who the main decision maker was and why. Best interest decisions had been taken and we could find no corresponding assessment prior to this stage which demonstrated that the person lacked capacity to make this decision for themselves.. This included the use of covert medicines, the removal of a person's cigarette lighter and giving personal care when the person did not wish it.

Where authorisations were in place to deprive a person of their liberty, for example in the freedom of their movement, the service had failed to monitor and re-new the authorisation when it had expired. This meant that these restrictions were illegal.

The nursing home used a monitoring system called PIR, an infra-red sensor system which detects movements within a person's room and through the bedroom doors. The system was used to be able to monitor people's movements as a mechanism for reducing falls. The manager told us it was a really useful tool. However, the policy for its use had not been followed. Documentary evidence was not recorded to indicate if a person had given permission for this equipment to be used. Where people were not able to give consent to its use, a mental capacity assessment had not been completed, a best interest decision had not been taken and a Deprivation of Safeguards had not been applied for or granted. People were being monitored by the service without the legal authority to do so which was an infringement of their human rights.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff within the nursing home told us they did not routinely receive supervision including clinical supervision for nurses. There had been a recent group supervision for nurses and all staff told us they could approach their line manager for advice or support. One member of staff told us they had received an annual appraisal which reviewed their personal development, however other staff told us they had not received an appraisal. The manager told us they would be addressing this as part of the development plan for the service. Within the residential home staff told us they discussed their personal development within their supervision, however they had not received an appraisal which set objectives for their development for the year ahead.

A training course entitled 'Care and Control' had been sourced by the previous registered manager. At the time, the training co-ordinator raised concerns with the previous manager about the content and suitability of this course. They told us they felt it was not appropriate for people who lived at the service; however they were advised the course would continue to be delivered. We looked at the syllabus of this course and found it may not be suitable for staff to support people with dementia and behaviours which may challenge.

The 'Care and Control' course is intended for services where conflict risk management is required and focuses on preventing the physical assault of 'self or others'. All staff had received this training and this was their approach towards supporting people where behaviour may challenge. A direct outcome of this training was that staff had developed a culture whereby they felt they had 'permission' to control and restrain' people and that this was an accepted standard. This training had not been routinely monitored for its effectiveness and which then informed future planning of training in order to meet people's needs.

In two of the nursing units we found the dining experience was not dignified and staff were not able to support people appropriately and manage the meal time in a timely way. During lunch time in the Marques unit, people were supported into the dining room before the hot food trolley had arrived. One person waited

45 minutes for their meal to arrive, however when it did arrive they no longer wanted to eat it.

There were not enough staff to support people appropriately, for example there were two people sat at a table with a third person in a specialised chair. The chair had not been turned to face the table for this person to be involved and interact with others. The member of staff turned their back on this person to support another person to eat and the third person waited for assistance to eat their meal.

The deployment of staff meant that staff interchanged between serving people in the dining room and people who wished to eat in their room. This meant the meal service was fragmented with people having to wait until staff were available in between staff serving people in their room

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

Following the inspection the provider contacted us with an action plan which documented that new staff who were going through induction at the time of the inspection were now in post. The use of agency staff had been significantly reduced. The course entitled care and control had been cancelled and a more appropriate training course had been sourced which all staff were to attend in February 2017.

In Deverill unit, staff asked people if they wished their meal to be cut up into smaller bite sized pieces, however did not continue to monitor that people required assistance. One person was dozing on and off for ten minutes and did not eat their meal. Staff did not ask the person if they wished their meal to be warmed up.

We carried out an observation of the dining experience within the Wylye unit of the nursing home. We found on both days the dining experience was disorganised. The dining area was too small to accommodate the number of people seated at the table and chairs were blocking the exit. Staff had to squeeze past the back of seated people to reach others, and this may have caused agitation as some people starting shouting out.

The atmosphere in the dining room was not calm and increasingly became more chaotic as the meal time proceeded. On the second day of the inspection, there was only one member of staff for the first 20 minutes of the lunch period. People were seated at the table with others sat in easy chairs around the room. The heated food trolley arrived five minutes after people were seated however it was 15 minutes before other staff arrived. In this time the sole member of staff had to deal with people becoming increasingly agitated as they saw the food trolley and wanted their lunch. This member of gave people a drink of their choice, however in the interim people became restless and started moving about. One person started to turn over the furniture.

On both days of our observation the same behaviours were exhibited by people and staff reacted in the same way. For example, one person who was sat in an easy chair had their meal placed in front of them. Staff told us this person could eat independently. They started to shout "help, help me". Staff supported them to eat as a way of managing their behaviour but this response did not support the person to maintain their independence with eating. Another person was given a spoonful of food by a member of staff whilst they stood over them before walking away to deal with another person. One person was sat on a dining chair but not at the table, a member of staff wrapped a towel around their neck without telling the person what they were doing. There was little staff interaction with this person as they ate their meal.

Staff were engaged in supporting people who required assistance to eat, this left others waiting for their meal. Forty minutes after the hot food trolley had arrived, only three out of six people sat at the dining table had received their meal.

People were asked for their choice of main meal the night before however this approach meant that some people may not be able to recall what they had chosen. Staff did not show people the plates of food to enable them to make a visual selection and did not describe the food people were being given. Pictorial menus were not available although the provider told us they had purchased these and staff should have been using them. There were no similar or written menus in the other units within the nursing home.

In Wylye unit, staff placed smaller dining tables together to make a larger one. A tablecloth was placed over the top however the table was not made inviting with flowers and condiments. Cutlery was not placed on the table but given with the meal. This was the same practice in the Deverill unit.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2004.

Within the residential home and three units of the nursing home, the design and adaptation of the premises were appropriate for people's needs. In Wylye unit, the décor was not dementia friendly in terms of sensory objects, points of interest such as items to pick up and find, and the use of colour on the walls to enable people to better navigate around the hallway and to their room. Some memory boxes outside people's rooms had been filled with pictures and memorable items. The lighting was low which created shadows on the carpet. This did not help people to make sense of their environment. The manager told us they were in the process of painting the hallway and had commissioned artwork to be painted on the walls to give warmth, interest and to support people to better orientate their way around the unit.

The dining room and lounge in Wylye unit were combined. This meant there was limited space and people's movements were restricted. At one end of the room, chairs were placed very close to each other which some people could view as encroaching on their 'personal space'. The dining area was in the other half of the room, however there was not enough space to house the number of tables required so that each person had the choice to sit at the table. A little way down the hallway was a larger room which had an adjoining kitchen with a hatch. The provider told us this room was intended for people in Wylye to use as their dining room, however it was mainly being used as a training room for staff.

In the nursing home and throughout the three days of the inspection, we noted that the call bell system was activated not only in the unit where it had been called but in the adjoining unit, either the unit below or above. The system did not allow the call bell to be sounded only from the unit where it was being pressed. There was a constant ringing of bells which meant staff had to check the monitors at each end of the corridor to see if it the sound was coming from their own floor. There were no lights to indicate to staff if the alarms had gone off on their floor, or any other mechanism to do this. Staff told us they felt they were not always dealing with the alarm bells as quickly as they could be.

In the nurses office we were unable to hold a conversation due to the level of noise of the call bell ringing from the floor below. We discussed the level of noise with the provider who told us they had tried to rectify the problem, however the system in its current state could not be changed. We found the constant ringing sound was intrusive to people and did not promote a calm environment. The home had not assessed if the noise could be a contributor to people and staff stress levels or agitation.

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

We observed the dining experience for people in the residential home. In the main dining room, tables were set with tablecloths, napkins, cutlery, condiments and fresh flowers. It was a sociable experience with people chatting and exchanging views. People were offered assistance to the table if required and some people choose to eat in the smaller dining room. A pre-dinner drink was offered such as sherry. The food

looked appetising, nutritious and people told us there was lots of choice on offer. People said they enjoyed their meals and there was always an alternative option if they did not like the selection on the menu for that day. Specialised dietary needs were catered for.

There was a range of training opportunities available to staff which included mandatory training such as, safeguarding of vulnerable adults, infection control, mental capacity and Deprivation of Safeguards (DoLS), dementia awareness and manual handling. The training co-ordinator had been in post for eight months and had devised a staff training schedule, sourced training and advised staff of when training was available.

The training co-ordinator had identified staff training which required updating and had a planned timetable in place for this. Nurses told us they had received all training relevant to their role and were being supported through the process or revalidation.

People had access to their GP and other health professionals such as a chiropodist, the mental health team and the care home liaison team. People attended hospital appointments as required, however referrals had not been routinely made to the Speech and Language Therapy department for the assessment and management of eating, drinking and swallowing for people.

Requires Improvement

Is the service caring?

Our findings

In the nursing home, people were not always supported to wear appropriate clothing and to maintain their appearance. On two days of the inspection we found people had not received the personal hygiene assistance needed to ensure their continence needs were met. The hems of another person trousers needed repair. Some people did not wear slippers or shoes which could be a trip hazard or risked damage to their feet without protection. This meant people's dignity was not promoted.

In both the residential and nursing home, people's care records were not kept secure to ensure they remained private and confidential. In the residential home, the door to the office was open and people freely accessed this room to speak with staff. Files were placed along a desk and these files contained information about the monitoring of people's care and support and which held their names. Likewise in the nursing unit, people's monitoring charts and activity information were freely available on a desk behind the nurses' station.

In the nursing home people did not have appropriate access to information which was made available to other people entering the unit. Before entering each unit there was a small foyer with key code access to the main unit. Within these areas were pictures of staff who worked on the unit, with their name and their role. The location of this information did not fully enable people to be as involved as they could be in recognising familiar members of staff.

People or families had indicated their end of life wishes, such as being cremated or buried and the person's spiritual needs. The end of life care plans in place were not holistic and did not reflect the scope of people's individual wishes and needs. For example, if they preferred to go into hospital or remain in the home, which people they wanted to be with them (and those they did not) and how they wished to spend their last days. Any additional information on how staff could provide comfort during these last days such as music the person liked and calming aromas. With regard to people with dementia, they were not supported to express these wishes whilst they were able to.

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

Staff had developed caring and trusting relationships with people. A member of staff in the nursing home told us "we ask people what they would like, I am cheerful. I hold their hands. I care. It's about the staff actions. I tell people they look good. We talk to people about their lives, we find out about their preferences and we share their interests." For example, one person had an interest in classic cars and the member of staff took in books on classic cars. This staff member also said that consistency ensured people felt they mattered.

In the residential home, staff were kind, caring and attentive to people's needs. People told us staff were "lovely", "always there for me" and "couldn't get better". People felt staff understood their preferences and were offered choices as part of their day to day routines. People's privacy was respected and staff ensured that people received personal care in their room. Staff knocked on doors and for the most part, waited until

people invited them in before entering the room. In the residential home, a member of staff explained how they ensured people's rights were respected. They said "we ask people about their preferences. We always ask and watch (their body language) that they are comfortable in our presence." We observed that staff knelt down at the person's height if they were sitting, made eye contact and waited for the person to respond to questions at their own pace. However, in the nursing home we found not all staff responded to people in a caring way because of the use of restrictive practices.

Requires Improvement

Is the service responsive?

Our findings

The recording of people's daily life did not enable a person centred approach to their care and support needs because information recorded by staff was ambiguous. Where people's behaviour was being monitored to enable appropriate support and care planning, staff reported behaviour as 'very violent towards staff', 'shouting and sarcastic', 'quite demanding', 'a little confused' and 'very vocal'. Staff had not described the triggers of the behaviour exhibited to assist staff with an evaluation of the person's actions. Members of staff showed a lack of insight into how some of the behaviours people living with dementia may present. Care plans did not provide staff with the guidance needed to distract people and when specific behaviours were exhibited to respond consistently.

Within Wylye unit staff had noted "staff to encourage X and X not to share the same communal areas'. The guidance did not say how and what staff were to do to prevent this. We observed the two people involved did share the communal area and were agitated and anxious when they came into direct contact with each other. When behaviours escalated staff therefore reacted rather than being responsive to these people needs.

One person had a support plan in place for diabetes with clear instructions for staff to carrying out blood checks at certain times to ensure the blood sugar levels remained stable. In another part of the care plan there was contradictory information which had come from the GP to reduce the checks. This information was not clear and could result in the person not receiving appropriate and timely care. Important assessments relevant to the health and welfare of people were not being routinely reviewed, for example one person's management plan for choking had not been updated since November 2015 to take into account changes in this person's care needs.

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

People did not always receive timely and appropriate care and support and where staff delivered support to people this information was not being routinely recorded. Monitoring charts for personal care such as, nail care, continence support, bathing and dental care were not being completed. We saw two people who did not receive the nail care needed and their monitoring charts had not been completed which demonstrated nail care had not been given.

We observed over two days that another person had not received support with their continence care. Their personal hygiene support plan stated "to be offered a bath regularly and change clothes regularly'. It was not stated how often this should be done to ensure the person's hygiene needs were met. The monitoring charts had not been completed to reflect timely and personal attention. Within the Wylye unit there were a high number of people who used continence products and little information in the care plan on the management of their continence needs. For example how often people should be prompted to use the toilet.

The care plans lacked sufficient guidance on enabling independence. For example, what the person could

do for themselves with regards to personal care and how staff could support this.

Daily records were not person centred in the way they described the person's day. Information about people's emotional wellbeing and mental health were brief or not recorded with standard entries such as, 'had a good breakfast, dressed, good fluids, supported to bed'. This meant information which may be vital to that person's wellbeing may not be highlighted to staff.

There was a lack of stimulation for some people in the Wylye unit of the nursing home. People were visibly frustrated which exhibited itself in chairs or objects being thrown, shouting, hitting the walls with a walking stick, going into other people's room, repeating phrases and wandering or pacing the hallway. We saw the activities co-ordinator put a film on, however this did not engage people. There was an activities co-ordinator who along with another co-ordinator provided group activities, events within the nursing home and one to one time for people. However, where people did not participate in the activities on offer, some people lacked stimulation which met their individual needs around communication, socialisation and meaningful occupation. There was a lack of evaluation to evidence that people's needs were being met and activities which were relevant to that person.

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

Care records within the nursing unit were sometimes incomplete and not dated, lacked appropriate signatures and did not include the designation of the person signing the document. Care was not being recorded at the point of delivery, for example on nightly room checks where two members of staff were available, 15 people had the same times when the checks occurred. Where people were on 15 minute observations, these were not routinely being recorded as required by the care plan. Staff used non descriptive statements when recording the care people had received, such as 'good fluids or good diet' without describing what that meant to the person and 'support refused' without saying what support was refused and how this should be followed up and monitored.

Care plans were either not reviewed or dates had not been recorded when care was reviewed. In the nursing home we looked at the care records of 12 people. Most of the individual care plans referred to 2015 and we saw no further reviews where the person and their family had been involved. This meant that people were not given the opportunity to participate in a review of how their care and treatment was being managed or that the care and support they currently received was reflective of their needs and wishes.

The manager told us there was a system in place for 'resident of the day'. This involved the care records of this person being reviewed. The reviews were not being effectively completed because they did not evidence where changes to the person's care had taken place and entries against the individual care plans were noted as 'no changes'.

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

Within the residential house there was a range of activities which people could take part in. One person told us "sometimes I will join in, but most of the time I like to see people coming and going, watching the world go by". On the day of our visit people took part in a quiz held in the lounge and we observed they enjoyed this activity. Activities were advertised on a notice board with many photographs of events people had taken part in. Likewise in some units within the nursing home activities and events were organised for people to take part in if they wished.

The service had a complaints procedure in place and this was available to people who used the service.

People and relatives told us they were satisfied with the way any concerns or complaints were handled. One person told us "I would tell a member of staff if I wanted to raise something. They try to sort things out quickly".

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in place. A new manager had been appointed and had started their employment during mid November 2016. They told us that following their induction they had spent time with the provider reviewing audits, carrying out observation of staff practice and getting to know people and staff. The manager had started the process of registering with the Care Quality Commission.

The audit and governance systems in place to assess, monitor and improve the quality and safety of the service provided were not fully effective. Shortfalls had been identified by the service such as, people becoming agitated due to having to wait a longer period of time for their meal to arrive, a lack of cutlery put out on the dining tables and people not being supported with their continence care. Action plans had been put in place to address these shortfalls yet remedial action had not been taken. We found the same issues and other shortfalls during the inspection.

Through discussion with the manager, it was clear that when they came into post they became aware of shortfalls in the delivery of safe and effective care. In particular around the lack of Deprivation of Liberty Safeguard applications being made and the need for consent to be given to the use of the PIR system. They were reviewing the audits in place with a view to making them more robust. The provider likewise had carried out quite detailed audits which did identify some of the issues we found, in particular around the dining experience for some people. In response, an improvement plan had been set up. However, the provider had not identified through the system of auditing that inappropriate restraint was being used on people and the Care and Control training made available to staff was not suitable.

The provider had failed to ensure there was a positive culture within the nursing home. The practice of restraint by members of staff in one of the units had become an accepted way of providing support to people. Prior to the new manager coming into the home, this practice was not questioned and had not been considered within the scope of governance.

We reviewed the syllabus of the restraint training for care staff called 'Care and Control' and found it was not appropriate for this service and the people they support. The provider told us they were not aware this training had been in place, as the previous registered manager had recommended the training and informed them the training was useful. The provider told us the training would be stopped immediately and they would source more appropriate training. Following the inspection the manager was to meet with staff to inform them they were not to use this practice in any circumstances and there would be a review of people's needs and training to support this.

Communication between staff members was not always professional. A communication book was used by the staff on the Deverill unit in the nursing home. It was used to pass information to each other about people's care needs, tasks and staffing issues. We saw an entry recorded on the 01 December 2016. It was in large print where a member of staff had left instructions for other staff which stated, "please put XX into bed late afternoon as too tired and agitated and red marks on face from table. Thank you". Underneath another member of staff had written "rude!" to describe their feelings about how the message was conveyed to staff.

This message was written in an unprofessional way It could have been viewed as offensive and dis-respectful towards others staff and demonstrated that the author was upset and angry when the entry was made. This meant the point of the message was missed as the staff reading the entry focussed on the attitude of the staff member instead of the message being conveyed.

In the nursing home we found there was a lack of leadership and structure within the units. This in part was due to the number of agency workers who were currently employed, however also to the inconsistencies in which the different units within the nursing home were operated. The manager told us they had recognised there was a need to have a more robust management structure in place to enable clear lines of accountability and a strong support structure for staff. They were reviewing the responsibilities of staff within the units and would be changing the leadership structure to include more senior care staff.

We discussed with the manager the model of care and subsequent staff approach within the nursing home. The provider and manager stated they were aware the nursing home had shifted towards more of a clinical model of care and felt they needed to also focus on staff supporting social care needs such as, providing assistance with activities of daily living, maintaining independence, social interaction and enabling the individual to have a wider role in their care.

Prior to the newly appointed manager coming into post, there had been a lack of managerial leadership which meant that lesson's had not been learnt when incidents had occurred. We saw that incidents and accidents had been recorded, although not routinely. There was a lack of investigation and analysis of incidents, findings were not shared and as a result staff practices and processes did not change.

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

Staff told us they felt the service was open and transparent and we found this to be the case. Staff told us they could approach both the individual manager's in the residential and nursing unit and felt supported in their role. People told us they felt the home was managed well and relatives confirmed this.

A member of staff on the Stourhead unit in the nursing home said the manager had made improvements since their appointment in November 2016. They said the team on this unit worked well together. Staff told us the new manager was good. A member of staff on the Deverill unit said the manager was "approachable and caring. Talks to residents. Friendly and professional." A unit lead in the Deverill unit said "the staff are usually happy in their work. There is good agency cover and (the manager) is supportive."

A questionnaire had been sent out to all families to ask for their views about the quality of the service which their loved one received. They would then use this to inform their planning and development.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not receive appropriate care and support which met their individual needs during meal times and were not supported to make choices about the meal preferences. Lack of social interaction and meaningful occupation for people. Care records were not person centred and relfect the person's preferences Regulation 9 (1) (a) (b) (c)

The enforcement action we took:

We issued a notice of proposal for the provider to submit a monthly action plan of their progress

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not always supported to maintain their hygiene and maintain their dignity. Staff were kind however not all staff were caring due to a level of restraint placed upon people. End of life care plans were in place however were not representative of a person centred approach which identified people's wishes. Regulation 10 (1) (2)

The enforcement action we took:

We issued a notice of proposal for the provider to submit an monthly action plan.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider was not working within the scope of the Mental Capacity Act 2005. Staff had varying levels of understanding of the act. Care plans were not underpinned by the MCA act and authorised restrictions on people and care plans did not clear guidance to staff on what decisions a lasting power of attorney could make and how to

	involve the person in these decisions. Restrictions were in place where by the lawful authority had not been sought or gained. Regulation 11 (1) (2)

The enforcement action we took:

We issued a notice of proposal for the provider to submit a monthly action plan

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe and effective infection control practices were not followed. A medicine room was not fit for purpose due to the cleanliness, access to the fridge and condition of the sink. People's care and support were not being effectively assessed, monitored and records were not being completed accurately or fully in order to offer appropriate care and support. Records were not person centred and there was a lack of guidance for staff in order to be consistent when delivering care. Information in charts and care plans were sometimes ambiguous and unclear. Staff were not always visible or available to people and there was a high level of agency staff who were not familiar with peoples needs. Regulation 12 (1) (2) (a) (b) (h)

The enforcement action we took:

We issued a notice of proposal to provide the Commission with an action plan of their progress each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff carried out acts intended to control and restraint people without the lawful authority to do so. Staff lacked understanding around safeguarding people from abuse. Risk management systems were not effective in protecting people. Regulation 13 (1) (b) (d)

The enforcement action we took:

We issued a notice of proposal to provide the Commission with an action plan of their progress each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014 Premises

personal care Treatment of disease, disorder or injury	and equipment The environment was not safe as a pathway between the two sites was unsafe. An electrical cupboard was accessible to people and a door way leading down to a cellar was left open and could cause injury from a fall. The dining room in the Wylye unit was too small to accommodate people's needs, the environment in the unit lacked stimulation for people. The call bell system was intrusive to people and staff in the nursing home. Regulation 15 (1) (b) (c)

The enforcement action we took:

We issued a notice of proposal for the provider to send us a monthly action plan.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had systems in place to audit the quality of the service received however concerns which had been identified were not followed up to ensure action had been taken. Not all of the concerns we found had been identified. There was a lack of direction and leadership in the nursing home. Communication between staff was not always respectful. Regulation 17 (1) (2) (b)

The enforcement action we took:

We issued a notice of proposal for the provider to submit a monthly action plan.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had received supervision including clinical supervision of nurses. The content of a course called 'care and control' was inappropriate for the intended client group. Staff were not skilled in supporting people with behaviours which challenged. Staff were not deployed in a way in order to give people timely and appropriate care and support. Regulation 18 (1) (2)

The enforcement action we took:

We issued a notice of proposal for the provider to send us a monthly action plan.