Cheyne Group Management Limited

Cheyne House Nursing

Inspection report

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Date of inspection visit:
30 June 2016
01 July 2016

Date of publication:
25 August 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 July 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.
We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection; by selecting the 'all reports' link for Cheyne House Nursing on our website at www.cqc.org.uk In addition we had received information of concern about the standards of care provided at Cheyne House Nursing.

This inspection took place on 30 June 2016 and 01 July 2016 and was unannounced.

Cheyne House Nursing is registered to provide accommodation and nursing and personal care for up to 26 older people or people living with dementia. There were 19 people living at the service on the day of our inspection.

There was not a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in September 2015 we asked the provider to take action to ensure they notified CQC when a request to lawfully deprive a person of their liberty was granted and operated effective systems and processes to make sure that they assessed and monitored their service. The provider sent us an action plan on 11 March 2016 and told us that these actions would be completed by 30 May 2016. On this inspection we found that the provider had not made all of the required improvements.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and breaches in Care Quality Commission (Registration) Regulations 2009. The provider had not ensured that people were kept safe from the risk of harm and neglect, did not ensure the proper and safe management of medicines; did not ensure the service was clean and properly maintained; did not work within the requirements of the Mental Capacity Act 2005, and there were weaknesses in the monitoring of the quality of the service and reporting statutory notification to CQC. You can see what action we told the registered provider to take at the back of the full version of the report.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood

their responsibility and made appropriate referrals for assessment. Five people at the time of our inspection had their freedom unlawfully restricted and two people had a lawful DoLS authorisation in place.

Standards of cleanliness were not always maintained throughout the service and there was a risk of cross contamination from soiled and damaged equipment and poor infection control practices.

Medicines were not always stored and administered safely by staff that had the skills and competencies to do so. Staff did not always refer people to other healthcare professionals and people were at risk of not receiving appropriate care and treatment in a timely manner.

There was not always enough staff on duty to care for people's needs. The registered provider did not support staff to undertake training to meet the health and wellbeing needs of the people who lived at the service.

People were not always provided with enough to eat and drink. The registered provider did not seek support and advice from appropriate health professionals when a person was a risk of weight loss or had difficulty swallowing.

People did not always have their risk of harm assessed and systems to monitor the quality of care delivered were insufficient to lead to improvements in the care people received.

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 were not always cared for in a clean environment.

People did not always have their risk of harm assessed appropriately.

There was not always enough staff on duty to meet people's care needs.

People did not receive their medicines safely by staff that had the skills and competencies.

Is the service effective?

Inadequate

The service was not effective

People were not always cared for by staff that were supported to undertake training to develop and improve their knowledge and skills.

The provider was not meeting the requirements of the Deprivation of Liberty Safeguards. Staff had not received appropriate training, and did not have an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were not always supported to have enough to eat and drink.

People were not always supported to maintain their health and wellbeing.

Is the service well-led?

Inadequate

The service was not well-led

The systems to measure the quality of the care provided were weak.

The provider did not inform CQC about statutory notifications.

There was a lack of consistent leadership in the service.

Cheyne House Nursing

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 30 June 2016 and 01 July 2016 and was unannounced. This inspection was completed in response to concerns we received and to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 02 September 2015 had been made. We inspected the service against three of the five questions we ask about services: is the service safe, effective and well-led. This is because the service was not meeting legal requirements in relation to that question.

The inspection team was made up of two inspectors on both days and a specialist professional advisor on 30 June 2016. A specialist professional advisor is a person who has expertise in the relevant areas of care being inspected, for example, nursing care. We use them to help us to understand whether or not people are receiving appropriate care to meet their needs.

Before our inspection we looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the manager, three members of nursing staff, four members of care staff, the cook, one housekeeper, the activity coordinator and five people who lived at the service and two visiting relatives. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included five staff recruitment and induction files, staff training information and meeting minutes. We looked at the quality assurance audits that the manager and the provider completed. We also looked at care plans for six people, daily care logs for seven people and medicine administration records for 19 people.

Inadequate

Is the service safe?

Our findings

Although relatives told us that they felt their loved ones were safe, on the day of our inspection we found that the provider was not managing risks to people in a safe and proportionate way.
We found that the response to the risk of harm was at times disproportionate to the likelihood of harm. For example, we saw that the fire door in the small conservatory was locked with a key to prevent people from entering the secure garden and the key was kept in the nurses' office. This meant that people could not access the garden or fresh air when they chose. When we queried the reason for this the manager was unable to provide us with an explanation or risk assessment, but did say they would look at alternative arrangements for storing the key.

People did not always have their risk of harm assessed and for some their risk of harm was not always reflected in their care plan. We saw that one person had bed rails in use on their bed; however, a bed rail risk assessment had not been completed; there was no recorded rationale that bed rails were appropriate for the person. Where risks to people's health, safety and welfare had been assessed, conflicting information in their risk assessments meant they were not receiving safe care and treatment.

People had been exposed to the risk of harm that could have been avoided where risks were not being managed effectively. For example, we found two different risk assessments were in use; the Malnutrition Universal Screening Tool (MUST) and an in-house assessment tool for nutrition. One person was assessed at risk of malnutrition on the in-house assessment tool and as at low risk of malnutrition on the MUST tool. This person was receiving prescribed nutritional supplements and the records did not show why they were receiving them or if they had been referred to a dietitian for a full nutritional assessment of their needs. A member of care staff told us they had been instructed to use a hoist to transfer a person from their bed to an armchair. This person had recently moved into the service and had not had their mobility assessed or risk assessed for the use of the hoist, this put the person and the staff member at risk of harm or injury.

We found registered nurses did not have the skills and competencies to safely order, store or administer medicines safely. One person who lived at the service went without their medicines to manage their behavioural needs for 10 days. Without this medicine they could place themselves or others at risk. We looked at 19 Medicine Administration Records (MAR) and found there were gaps when medicines had not been signed as given. When a medicine was not given the correct code was not used to show why, or a code that was not identifiable was used. One person had received medicine that had expired on 27 June 2016 for three consecutive days until we identified the error on 30 June 2016. Another person with a diagnosis of dementia was prescribed a sedating medicine and their dose over a 24 hour period was greater than the recommended maximum daily dose for their age and the medicine was contraindicated in people living with a dementia type illness. The fridge temperature was out of the normal range for several weeks and was not actioned by any of the registered nurses or the manager until we raised it as an issue with the manager on 30 June 2016. We read the external pharmacy audit undertaken on 17 September 2015 and saw that the out of range fridge temperature recording and gaps on MAR charts had been identified at that time. However, action was not taken to address this and people continued to be at risk of harm.

We observed the lunchtime medicine round and saw that medicines were not administered safely by the registered nurse. The registered nurse did not take the medicine trolley to people in their downstairs bedrooms or to people sitting in one of the front lounges, but administered medicine from the trolley in the conservatory and then carried a pot of medicine to people. Although the medicine trolley could not be taken upstairs, there was ample space downstairs to take the trolley from room to room. There was a risk that staff could become distracted or that medicines could be spilled before being administered. This placed people at risk of not receiving their medicine. We also saw that the registered nurse did not always sign for medicines when they had been given. For example, we looked at the MAR chart and medicine blister packs for one person and saw that six early morning medicines had been removed. However there was no signature on MAR chart at 11.40am to confirm that the medicines had been administered. The registered nurse responsible told us, "She got up late. I gave [them] to her about 9.30am." We asked the registered nurse if they had the competency to administer medicines and they said, "I did some online medicines training last month. It was very helpful. Nice to keep yourself updated. When I started four months ago, a registered nurse [name of registered nurse] showed me what to do [re medicines]. Since then, never had anyone supervise my practice. I am not aware of any programme for checking our competence."

We observed that one person's medicine was not taken for over 24 hours and left on their bedside table. We looked at their care plan for medicines that stated, "Medicine to be given by a competent nurse." However, we found evidence that care staff lacked the competency to give people their medicine safely were asked to support people to take their medicines covertly by the registered nurses. For example, a member of care staff told us that they did not like being asked to give people their medicine covertly in their breakfast and said, "Tablets are tipped into their porridge. I don't think I should do it. I'm not qualified. They spit them out."

We looked at the records for three people who were receiving their medicine covertly and noted that there were issues around their safe management. We found that one person had not had their covert medicines reviewed by the pharmacist since June 2014. Another person had not had their covert medicines reviewed by the pharmacist although there was record in their notes to say that their GP had requested this before staff gave the medicines covertly. We discussed this with the manager who arranged for the pharmacist to review all covert medicines.

We saw that there was a discrepancy in the stock levels for a strong pain killing medicine for a person who was no longer in the service. We found an unsigned hand written note in the medicine cupboard that read, "Patches sent with patient to hospital." Staff did not follow the correct procedure when they transferred the medicines as there was no record of how many patches had been sent. In addition, national guidelines on the safe management of medicines were not followed and we found that the last entry in the record book had not been counter-signed.

The provider did not have systems in place to safely manage risks from clinical waste. We saw two sharps boxes for used needles and syringes were in use and stored in the clinical room. One was full and had not been sealed shut and the other was half full. We spoke with a registered nurse who told us, "Second box started some weeks ago as nearly half full. Don't know why we had two on the go. No one has taken responsibility for disposing of full one." There was an increased risk of injury from the full sharps box as the clinical room was also used as the hairdressing salon.

Staff were not supported to provide care that was centred on a person's needs which resulted in care that institutionalised and people experienced social isolation. For example, some people who were cared for in their downstairs bedrooms, never left their bedroom, were seldom provided with the opportunity to sit out of bed if they were able, all received a pureed diet, and were not given a choice of meal as care staff decided

what people had to eat. We noted that some people cared for in their bedrooms had been assessed at risk of social isolation. However, our observations of care identified that despite these risk assessments people remained socially isolated, that staff only interacted with them when providing care and they received no input from the activity coordinator. When we asked why people were cared for in this way we were told, "It's what they have always done. They can't communicate." One person's relative commented, "They are devoid of social stimulation in their room. Some staff have the skills, some staff need help and support on how to engage and support people."

Staff did not always recognise that people were at risk of harm and told us that people were safe living at the service. We saw that staff had access to a copy of the local authority's safeguarding policy. However, when we spoke with staff, we found that several of them did not know how to share their concerns out with the service and had not heard of the local safeguarding authority. If they had witnessed or had concerns about potential abuse we could not be assured that it would be recognised and dealt with appropriately to protect people.

We saw that several areas of the service were not clean and this put people and staff at risk of cross infection. We looked at the sluice and found soiled commodes and personal washing bowls were not clean and not stored safely. The sluice was cluttered with the housekeeper's equipment and we could not access the hand wash sink. We found staff did not follow best practice infection and prevention control guidelines. We saw a member of care staff leave by the front door to go on their break in the front garden wearing their protective apron that they had used to deliver care. We observed a member of care staff carry soiled linen close to their chest without protective equipment such as gloves and an apron and the soiled linen was not placed in plastic bag designed for this purpose. There was a risk of cross infection if the staff member came into contact with a person who lived at the service or another staff member. Cross infection is when one person transfers their germs to another person or germs are transferred from equipment to a person.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people who used the service and staff were at risk of injury from damaged equipment and furniture. For example, we saw a bed with a broken brake pedal, a damaged commode, an arm chair with ripped fabric and a damaged bed end. The curtains in several bedrooms were hanging off the curtain rail. There were no systems in place to monitor the safety of the equipment and to report items in need of repair.

Staff spoke about their impression of the service. One staff member said, "The home could be upgraded. It needs new furniture and decorated. It's kept as clean as can be, but it always looks tired and dirty." Another member of staff told us about their first impression of the service and said, "I was shocked. I thought I had stepped back in time, when I saw the shared bedrooms. But things have improved, the lounge has been decorated and we have a new carpet in the dining room." We found that the dignity curtains in shared bedrooms were an infection control risk as they did not fit properly and lay across the bottom of beds or on furniture.

The laundry room was not fit for purpose. There were no separate clean and dirty areas and there was a risk of cross contamination. The laundry room was unclean. We found a build-up of dust and debris on top and behind the washing and drying machines.

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

The manager told us that they did not have a dependency tool to calculate the amount of staff and skill mix needed to provide safe care and treatment to people. They told us that the provider had a system, but were unsure how effective this was as the provider did not know people's needs. Nursing and care staff told us that there was not enough staff on duty. One registered nurse said, "There is never enough staff. Puts more pressure on care staff. We are late finishing [our shift]. If we are short of staff, we're trying to catch up all the time. It has happened a lot lately. It impacts on the ones in bed as they might not get their diet on time."

A member of care staff said, "There is not always enough staff. If they ring in sick at short notice, there is no cover." We found that there were insufficient staff on duty to meet people's individual care needs. People were not always able to call staff for support when needed. We saw that most downstairs bedrooms and shared areas of the service did not have call buzzers. We observed seven people sitting in one of the lounges after lunch on the first day of our inspection without any means of calling staff for assistance. We watched people sit and do nothing for 20 minutes and no members of staff entered the room during that time to ensure people were safe. After 15 minutes we observed two people becoming increasingly agitated and one started to shout and swear at the other. We informed the manager of the deteriorating situation in the lounge. At that time we noted that care and nursing staff were chatting together in the nurse's office or the kitchen. However, one person's relative told us that they had been present with their loved one in their upstairs bedroom and staff had responded to their buzzer.

We looked at staff rotas for the previous four weeks and found that when members of staff were on sick leave it was not always apparent that their shift had been covered by agency or bank staff. On day two of our inspection there were staff shortages in the morning due to sickness. The manager covered the deficit with an agency carer and a registered nurse who was off duty. However, we saw that one person who lived at the service had been assessed as needing one to one care to keep them safe but did not receive this until the agency carer arrived mid-morning.

We looked at staff files and saw that there were serious shortfalls in the recruitment processes. We found gaps in the safety checks that were necessary to ensure that a prospective staff member was suitable before they were appointed to post. For example, we saw one member of staff did not have a professional reference or past employer reference but had used their partner and a friend as their referees. We noted that a registered nurse had been appointed without any references. There were no interview notes and the recruitment checklists were incomplete. Therefore we were unable to determine if staff had gone through the correct recruitment process.

The manager had recently introduced daily, weekly and monthly cleaning schedules for housekeeping staff to record the cleaning duties as they were performed. Although the manager told us they had explained to housekeeping staff what was expected of them , we found that cleaning staff had not recorded what they had done and there was no record that cleaning had been carried out. We spoke with one housekeeper who told us that they were unsure how the new system would work as they had only cleaned four bedrooms that day and the cleaning schedule expected that all bedrooms would be cleaned every day. They said, "I will do as many as I can, but some of the bedrooms won't be done today, despite the schedule."

The lack of time to complete a job effectively was also voiced by a registered nurse. When we shared our concerns to the registered nurse following our observation on the lunchtime medicine round, they stated that the lack of time they had impacted on their ability to manage medicines effectively.

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

Inadequate

Is the service effective?

Our findings

We found registered nursing staff and care staff did not have the competencies, skills and experience to deliver safe and effective care and treatment. Training records for the last 12 months identified that four nursing and care staff from a total of 33 staff had received training in skin care and nine nursing and care staff had received training in nutrition. In addition, one out of 10 registered nurses had received training for the safe administration of medicines and three registered nurses had received care plan training. No staff had received training in falls prevention. When we reviewed peoples' care plans we found that staff lacked an understanding of the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) because the provider had not ensured that they were properly trained in MCA and DoLS. A member of nursing staff told us that they had not received any training when they were first appointed and said, "I've had no training. All mandatory is done in my own time on my computer at home. I've had no face to face training or assessments."

We spoke with a registered nurse who was appointed to their post in 2015. They told us about their induction and said, "I shadowed another registered nurse for a couple of days. I didn't have an induction handbook, but I did some training on the computer." Another registered nurse who had been in post for four months said, "One day induction was not enough. I was thrown in at the deep end; even two days would not be enough. I received an induction pack, but it didn't tell me anything about standards of care or the homes values."

We saw that some staff had been nominated as lead person for key topics. For example, two members were link nurses for infection control and one of them attended regular peer group meeting arranged by the local authority. Other staff were nominated as leads for dementia care, nutrition, end of life care and wound care management. However, we did not see how these key roles impacted on the standard of care that people received as these key areas were not addressed in practice. Furthermore, the manager told us that the list was out of date and that some staff did not have the skills to be effective in their link role.

Staff did not always receive feedback on their performance or have their training needs identified for the following year. We looked at appraisal records and found that 21 out of 33 staff had not received an annual appraisal since May 2015. The supervision records showed that supervision sessions were inconsistent. Some staff had not received supervision in the last 5 months where as others had received supervision up to four times in that period. Registered nurses shared their experience of their role and one said, "I've had no supervision and one appraisal since I started. I'll look for a new job, there is not enough nursing care in my job, there is no hands-on [direct personal care], it's all paperwork, and I have no responsibility for my link nurse role."

Staff did not have the skills to recognise poor practice or to challenge each other when omissions in care were identified We looked at daily care charts for several people and saw that there were days when personal care was not given or it had not been recorded as given. For example, one person had not received personal hygiene for two days, oral hygiene for seven days and the condition of their skin was not recorded for seven days. This had not been picked up or identified by care workers or nurses which meant they could

not be assured people were receiving appropriate care. We noted that another person who had recently moved into the service was assessed at high risk of pressure damage to their skin, and their care plan stated, "Needs monitoring and intervention by a trained nurse." There was no record that the person had the condition of their skin checked from 23 June until the day of our inspection. A member of care staff told us that they were expected to undertake tasks that they did not have the skills for. They said, "Carers are being asked to do dressings, but I won't do it. I'm not trained in it." A registered nurse spoke of their lack of knowledge of skin care and said this was due to their background being in mental health nursing and not general nursing. This shortfall in the registered nurse's knowledge had not been identified by the provider and presented a significant risk to people living at the home.

We observed nursing and care staff provide care to people and found that they lacked awareness of the special care needs of a person living with dementia. For example, a member of care staff had put a music disc on to play to a person who was cared for in bed and unable to do anything for themselves. However, the staff member did not understand that playing Christmas music in July might be very confusing to someone suffering from memory loss.

Staff exchanged information on a person's wellbeing and any changes to their care needs at shift handover. Members of care staff told us that they were not always invited to attend handover or were not given appropriate information and therefore were not kept up to date with any changes to care. One member of care staff said, "We don't always get a handover. If it's an agency nurse we don't get one." Another member of care staff said, "If I was to change anything it would be communication between staff. At handover I am left wondering what has gone off. What does "had a quiet night" mean? I feel like a headless chicken." This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that people's consent to care and treatment was not always sought by staff. For example, we found consent forms in care files for people to receive care and treatment and to have their photograph taken for identification purposes. However, we saw that several consent forms were blank and others that had been completed had not been signed by the person or their representative.

The 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.

An inconsistent approach was taken by registered nurses in regard to mental capacity assessments and best interest checklists. We found some good practice where people who could not make decisions for themselves had a range of capacity assessments covering all aspects of their care, such as assistance to go to the toilet and support with taking diet and fluids. However other people who may not have had capacity to make decisions did not have any assessments whatsoever.

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).

The provider did not always comply with current legislation. For example we looked at the care charts for a person who was receiving one to one care for 14 hours a day and under constant supervision during this time. However, the service had not issued an urgent DoLS authorisation and a request for a standard authorisation had not been made to the local authority. In addition, this person was receiving a strong

sedating medicine to chemically restrain them to manage their unpredictable behaviour. The person's records showed that they were either asleep or drowsy most of the day and ten out of the last 15 doses of medicine had not been given for this reason.

Furthermore, six people who had their bedrooms on the first floor had their freedom of movement restricted and were restrained by locked doors. They remained in their bedrooms after their evening meal until breakfast time the next morning. The door at the top of the stairs was locked and controlled by a key pad. There were no toilets upstairs for people to use and because of the locked door people were unable to access a downstairs toilet at night so people were unsupported and dependent on being able to call for assistance to have their needs met. We were told that the people on the first floor lacked capacity to make decisions about their care and treatment; however, we found that decisions had not been made in their best interest.

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. We found that two applications to lawfully deprive a person of their liberty had been submitted to the local authority and were approved and a further eleven authorisations were waiting on assessments. We identified a further five people who lacked capacity to make a decision to live at the service or make decisions about their care and treatment, were being unlawfully deprived of their liberty as they had not been referred to the local authority for a DoLS authorisation.
This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not provided with a well-balanced and nutritious diet that met their needs and preferences. Some people had been assessed as at risk of malnutrition and weight loss. We saw that where people had their food and fluid intake recorded that this was not always an accurate account. For example, we saw recorded on one person's chart, "Porridge ate half." However, it did not record how much was initially offered, so staff were unable to calculate how much the person had actually taken. Another person's total fluid intake for the previous 24 hours added up to 450mls, this is equivalent to two glasses of water, and well below the daily recommended fluid intake. Although some people had jugs of water in their bedroom, their prescribed fluid thickeners were not kept in their bedroom, but were stored in the locked clinical room. People with swallowing problems could receive a drink without it being thickened to the correct consistency and this increased their risk of choking.

There was a four week menu plan. However, there were no seasonal alternatives, the cook did not discuss the menus with people and people had not been involved in planning the menus. The cook told us, "We don't change it seasonally. It was introduced with a joint discussion with the then manager. I think there was a discussion at the resident and family meeting, but I'm not in attendance so I don't know." There was one main course option at lunchtime and this was written on the menu board in the dining room before breakfast. If a person, did not like the main course we saw that an alternative was provided. People who used the dining room were offered a choice of sandwiches and homemade cakes at teatime, but there was no fresh fruit available.

There was little communication between the cook and the nursing and care staff about a person's dietary needs. For example, the cook told us that they were not aware that anyone was at risk of malnutrition, and said, "I would have thought we have some." We found that there was no information recorded by the cooks of a person's individual food likes and dislikes, food allergies, swallowing ability and special diets. Although the cook told us that they "kept this information in [their] head." the lack of a system meant that the provider could not be assured that people's nutritional needs were being met. The provider was reliant on

supplements to fortify food for people at risk of being undernourished. The cook did not fortify foods with milk, cream or butter and said, "If we are having [name of dessert] I add cream for the soft diets, other than that I don't do anything with my cooking, it's dealt with by the carers through supplements."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with care staff who informed us that people who were cared for in their bedrooms were not given a choice at meals times and said, "All them in their rooms are assisted. We know who eats meat and who can't tolerate meat, even if pureed. There's no choice. They can't really talk so can't make a choice. We just decide on the day."

People who lived at the service were not always supported to maintain good health. Although people were registered with their local GP, staff did not make timely referrals for professional healthcare advice, treatment and support. We saw that this omission impacted on a person's overall wellbeing. For example, people who were cared for in bed did not receive professional input from a physiotherapist to help reduce the risk of muscle waste and immobility. People at risk of pressure damage were not referred in a timely manner to the tissue viability nurse specialist for advice on treatment and appropriate pressure relieving surfaces such as mattresses and special cushions and we found that some people had developed serious pressure sores. There were no records to show that people at risk of weight loss due to poor health, loss of appetite or with swallowing difficulties were referred to the dietitian or the speech and language therapist. When we asked to see records of professional visits and assessments we were told the records had been archived. Therefore staff had no up to date information to assist them to plan people's individual care needs and no recent referrals had been made

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

Inadequate

Is the service well-led?

Our findings

At our previous inspection in November 2015 we identified that the registered provider did not operate effective systems and processes to make sure that they assess and monitor their service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that although some improvements had been made we found other concerns and the registered provider continued to be in breach of the regulation. We found where audits had been carried out, that lessons had not been learnt and changes were not made to improve standards within the service. For example, two bedrooms occupied by people at the time of our inspection had a strong odour of urine and we requested that the rooms be cleaned during our inspection. The odour from carpets had been identified on a health and safety audit on 6 June 2016 and had not been actioned. A mattress audit had been carried out on 14 June 2016, and although concerns had been identified, there was not an action plan in place with timescales to address these concerns and people continued to be cared for on inappropriate mattresses. The community pharmacist undertook a medicines audit in November 2015. The areas for improvement had not been actioned and we found the same concerns on this inspection. The provider did not ensure that when areas of concern had been identified that staff were kept up to date. A registered nurse told us that they were not always made aware when there had been an incident and a member of care staff said, "When we report things to them [registered nurses] we don't know if they follow it up."

The provider was not using opportunities to get feedback from staff to improve their skills and the quality of care. We looked at the minutes of a meeting for all staff held on 17 May 2016. Eight members of staff attended and topics included that registered nurses needed to attend a training sessions on completing medicine administration records when medicine had not been taken and for night staff to complete records correctly. Our observations identified that both topics had not been adequately addressed since the meeting. We saw the impact of the lack of training in this area during our inspection. A registered nurse told us that they had not attended any staff meetings since they joined the service 11 months ago as they had not been working on the meeting days. Individual staff groups had meetings; however, these meetings were infrequent. For example, care staff last met in November 2015 and housekeepers in December 2015.

The last CQC inspection report was not made available to people who live in the service and their relatives. The inspection ratings were inaccessible to people and their relatives, as they were displayed on an information sharing board above head height and the quality of the print was poor. We brought this to the manager's attention who placed it at eye level.

There had not been a registered manager in post since July 2015. Since that time there have been three managers. The current manager had been in post five weeks and told us that they had commenced the process to be registered with CQC. People and their relatives had observed this lack of continuity of manager and one person's relative said, "My mother has been here over two years and there has been a lot of changes of manager. It's unsettling for people." Staff spoke of the difficulty in adjusting to new managers. One said, "Change of new managers; we just have to be done with the job and get on with it. Each one does

something different and we don't know if we are coming or going." Another member of staff said, "I think it's a good place to work. Although everything changes every time we have a new manager." Although staff were dissatisfied with the frequent change of manager they all spoke positively about the new manager. Staff told us that they were approachable and had made positive change in the short time they had been there. The manager told us that they did a daily walk about the service, but they did not have a system to maintain a record of their findings and there was no evidence that any concerns had been identified and actioned. For example, one of the inspection team was shown into each bedroom by a member of nursing staff and found that following the deaths of two people who used the service in the previous two weeks that their bedrooms had not been cleaned and personal daily notes had not been removed and stored appropriately. Items that had not been removed included: a blackening banana, a used clear syringe on the floor and rubbish in the waste bins. This showed that any checks on premises and cleanliness were ineffective. The provider is required to make the statement of purpose available to people and their relatives, However we found that it was not available to them.

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding, infection control, pressure ulcer prevention and care and the wound management policy. However, the provider did not have systems in place to ensure that this guidance was put into practice to provide a good standard of care. The wound management policy included the need for staff to inform a tissue viability nurse specialist when a grade three or above wound was identified and that their GP should be informed. We found that this was not being followed and people were being placed at significant risk.

We found that people's personal information was not stored securely and was easily assessable to visitors to the service. Care files were stored on open shelves in the nurses' office and the door was left open when unoccupied. We brought this to the manager's attention on the first day of our inspection. However, we observed the door open when the office was unoccupied several times on day two of our inspection. The administrator and manager had their offices in the attic, where personal information for staff and people was stored. We saw that the door from the first floor to the attic was not locked and this could be easily accessed.
These issues are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a culture at the service that was task orientated and not based on best practice guidelines and current research. For example, a member of nursing staff told us, "We have six people cared for in bed. They get up on alternate days. It's always been done since I came here, it's not evidenced based." A member of care staff said, "We have a routine, but the work impacts on us at dinner time. We do the turns and assisted feeds." Another member of care staff said, "I don't like it. But when I raised what we do I was told, "that is how it is done." It's the way it is; you can get into it, have to do it. Just fall into it." This culture stifled any opportunities to improve the experience of people receiving care at the service and reduced the quality of their lives as they were unable to make day to day choices.

The registered provider has a legal obligation to notify CQC without delay when a person in the service had died. We found that although we had not received any notifications of death in the last 12 months, the manager confirmed that several people who used the service had died in the last 12 months. This was a breach of regulation 16 Care Quality Commission (Registration) Regulations 2009

The manager sent three notifications to CQC on day two of our inspection. In addition, the provider did not notify CQC when a request for a standard DoLS authorisation was made and granted. This was a breach of regulation 18 Care Quality Commission (Registration) Regulations 2009

Some staff told us that they enjoyed working at the service. One staff member said, "It's all good, there is nothing that I would change or improve." Another member of care staff said, "It is nice, care staff are brilliant and most nurses are really nice. Some are harder to work under."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered person failed to notify CQC when a person in their care died. Regulation 16. (1)(a)(b)

The enforcement action we took:

Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify CQC when a request to lawfully deprive a person of their liberty was requested, withdrawn or granted. Regulation 18. (1) (4A) (a)(b) 4B)(a)(b)(c)(d) (5)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons failed to ensure that risks to people's safety and welfare were properly assessed and action taken to mitigate risks. This included risks associated with people's health, in the environment, from lack of measures to control infection and in the way that medicines were managed. Regulation12 (1) (2) (a)(b)(c)(e)(f)(g)(h)

The enforcement action we took:

Notice of decision to restrict admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons failed to ensure that people were protected from abuse and improper treatment and did not prevent people from being unlawfully deprived of their liberty. Regulation 13. (1) (2) (4)(b)(c)(d) (5)(d) (7)(b)

The enforcement action we took:

Notice of decision to restrict admission

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider did not ensure that people always had their nutritional and dehydration needs met and had the support to do it. Regulation 14. (1) (2)(b) (4)(a)(b)(d)

The enforcement action we took:

Notice of decision to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person did not ensure that equipment was fit for purpose and properly maintained. Regulation 15. (1)(a)(b)(c)(d)(e) (2)

The enforcement action we took:

Notice of decision to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have systems in place to assess, monitor and improve the quality of care to people. Regulation 17. (1) (2)(a)(b)(c)(d)(e)(f) (3)(a)(b)

The enforcement action we took:

Positive condition to maintain accurate and complete records. Notice of decsion to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure that there were sufficient numbers of suitably qualified, skilled and experiences staff on duty. Regulation 18. (1) (2)(a)(b)(c)

The enforcement action we took:

Notice of decision to restrict admissions. Postive condition to provide registered nurses with competency assessments, supervision and trianing.