South Tyneside MBC

Perth Green House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 and 28 January 2016 and was unannounced. We last inspected Perth Green House on 23 January 2014 and found it was meeting the legal requirements we inspected against.

Perth Green House is a care home without nursing and provides short stay services for people who need rehabilitation support. It mainly supports older people, but also younger people with learning and physical disabilities. The service is provided by South Tyneside Council. The building is on the ground floor level with shared dining and sitting areas, bathrooms and toilets.

Perth Green House can accommodate 30 people. At the time of the inspection there were 15 people using the service.

A registered manager was registered with the Care Quality Commission at the time of the inspection. However they had recently applied to cancel their registration with an effective date of 1 August 2015 and they had been absent from the service since 1 July 2015.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous manager had recorded a log of incidents that had been reported to the safeguarding team for consideration. They had not completed any investigation or analysis to identify any trends or areas for improvement. No logs had been completed since November 2015 but the manager told us there were two incidents to be added.

Accidents and incidents were recorded. Analysis of these had been completed until October 2015 when it stopped. The manager said they did not know why it had stopped. The analyses that had been completed had not resulted in any action plan or changes to practice to reduce incidents or accidents in the future.

Medicines were not managed safely, there were gaps on medicine administration records and no action had been taken to identify why. One person had run out of one of their routinely prescribed medicines. Medicine care plans were generic, and there were no protocols in place for 'as and when required medicines.'

Care plans varied in the degree to which they were person centred but they did not contain detailed information about the support people needed. The specific equipment, aids and adaptations people needed were not always specified on care plans. This meant people were at risk of receiving inconsistent and inappropriate care due to the lack of detail for care staff to follow.

Complaints were not always logged so there was no record of any action taken to resolve concerns or

improve service provision. People had completed surveys but no action plan was generated to address any comments they raised. Staff surveys had not been completed as recent practice at South Tyneside Council has been not to undertake staff surveys.

Environmental risk assessments had not been reviewed in line with the planned review dates. The manager was unable to show us an emergency contingency plan and fire drills had not been completed in line with the fire risk assessment.

One care staff member we spoke with told us they had not had a supervision meeting for a while and another said they [supervisions] don't happen now. Staff had not had an annual appraisal. There were gaps in the delivery of training and staff administering medicines had not had their competency observed. Senior care staff were completing moving and handling risk assessment but half of them had not been trained. Care staff completed care plans and commented, "We haven't been trained we just pick it up as we go along."

It was the provider's policy to complete disclosure and barring service checks on care staff every three years, however this had not been carried out.

One wing of Perth Green House was described as the 'office wing.' Care records were stored in an unlocked filing cabinet in an unlocked room so anyone accessing the office wing could also access confidential information.

The specific dietary requirements of people was on display near the serving area in the dining room and could be seen by anyone in the area, which did not promote their dignity or privacy.

Some records described people as 'fallers', and stated 'two carers need to put the person in the shower.' The manager described some rooms as 'PD' rooms, referring to physical disability which meant they had been adapted for people living mobility needs. These group labels contravened people's individuality and dignity and were not person centred.

The service manager said they had not completed any audits and there was no service improvement plan in place. Following major safeguarding meetings with the council and other agencies, an action plan had been put in place for the service to make improvements. The timescale for completion of actions was recorded as immediate or 30 July 2015. We noted that several of these actions had not been completed. A local authority commissioning visit had taken place on 17 and 19 January 2015. The report had identified some areas for development and some priorities.

All of the staff spoken with except one said there were enough staff to meet people's needs. No staffing tool was used for calculating the number of staff needed to meet people's needs.

The manager explained that people needed to have the capacity to consent to care and rehabilitation in order to move into Perth Green House so they did not currently support anyone who had an authorised Deprivation of Liberty Safeguard.

People told us they enjoyed a good variety of food which was very tasty, and two people told us that they had gained weight whilst at Perth Green House which they were pleased about.

People had regular contact with an intermediate care nurse and physiotherapist who were based at Perth Green House. We also saw that visiting professionals supported people, such as the district nurse and a

general practitioner.

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.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines were not managed safely. There were gaps on medicine administration records and one person ran out of their prescribed medicines.

There had been a significant number of safeguarding consideration logs completed but no investigation or analysis had been made to reduce the level of risk.

Risk assessments had not been reviewed in line with the specified review dates. There was no emergency contingency plan.

Accidents and incidents had not been analysed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received supervision or appraisal in line with the provider's own policy.

Staff had not received relevant training to support them to carry out their role.

Some people gave signed consent for the care and treatment they received and to indicate that they agreed with their care plans.

Is the service caring?

Requires Improvement

The service was not always caring.

The privacy of sensitive information about people was not always maintained.

Some records described people as 'fallers,' and some rooms were described as 'PD' rooms which meant they had been adapted for people living mobility needs.

Staff interactions were kind and considerate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not contain detailed information about the support people needed.

The aids and adaptations people needed were not always specified in their care records.

Complaints were not always logged so there was no record of any action taken to resolve concerns.

Residents had completed surveys but no action plan was generated to address comments raised.

Is the service well-led?

Inadequate

The service was not well-led

There were no quality assurance systems or audits in place to improve the quality of the service.

Feedback from others had not been acted upon to improve the quality of the service.

There was no registered manager in post.

The culture and morale of the staff team was poor. Staff said there had been several management changes which had been difficult as they all changed the systems.

Perth Green House

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 28 January 2016 and was unannounced. This meant the provider did not know we would be visiting.

The inspection team was made up on one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority commissioning team, Clinical Commissioning Group, the safeguarding adult's team, and healthcare professionals.

We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with five people staying at the service and two visitors. We also spoke with the manager, three senior care staff, five care staff and one ancillary staff member.

We reviewed five people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine records for five people, as well as records relating to the management of the service.

We looked around the building and spent time with people. We used the Short Observational Framework for

Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who did not talk with us.

Inadequate

Is the service safe?

Our findings

People who stayed at the service had their medicines managed by care staff. Medicines risk assessments were generic and contained the same information apart from the person's name and date of admission. Each risk assessment stated that staff were to support with ordering, delivering and administration as per the persons prescription and that staff were to administer all medicines as per the prescription. This was also the case for one person whose medicine care plan stated their medicine was ordered and administered by the district nurse. Staff confirmed that the district nurse managed this person's medicines. This meant the risk assessment was incorrect.

There was no evidence that protocols were in place for people who were prescribed 'as and when required medicines' such as for pain relief. Senior care staff administering medicines relied upon people being able to confirm to them if they needed this medicine rather than having guidance to follow to assess whether the person needed the medicine.

We observed medicines being administered. Some medicine administration records were hand written and others were pre-printed. One senior staff member said, "We are going back to using the pre-printed ones as there's less opportunity for error with those as we don't need to put all the information on it." Several people had gaps on their medicine administration record (MAR). There was no corresponding note to explain the reason for the gap. One senior said, "Oh, it will have been given but not signed for." No check had been made of this as no audits were taking place to ensure people's medicines were administered as prescribed.

Another person had run out of one of their prescribed medicines and for four days had not received their medicines as prescribed. There was a note on the reverse of the medicine administration record (MAR) to say it had been ordered. A senior carer said, "It was ordered but it didn't come in."

We spoke with the manager about this and they did not comment. A senior carer said, "We do a stock check of medicine, and we order medicines 10 days before it runs out." We asked the manager if they completed a check of the MAR charts to ensure appropriate ordering and administration and they said, "No I haven't done any audits."

Another person had refused one of their medicines over a 10 day period. There was a post-it note from a nurse reminding staff to ensure the person took their medicine. We spoke to the manager and senior about this. They explained that refusals would be picked up through the audits however they also told us no audits had been completed. They added that calls would be made to doctors and it would be recorded in the communication book. The manager said, "We do have an audit tool but it hasn't been used by seniors." There was no evidence of any audits of medicines having been completed other than a count of tablets which was not effective in ensuring safe administration. This meant medicines were not managed in a safe way for the people using the service.

We asked the manager about refresher periods for medicine training and they said, "It's each year. It tends to be the trained staff who administer." They added, "Some staff are waiting for competency checks so they

will be done." The training matrix provided by the manager showed that none of the seniors administering medicine had had an observation of competency completed but they had attended training with the last year.

Accidents and incidents were recorded. The manager said, "I think [previous manager] was completing the falls forms, it wasn't done for December so admin have gone through the files and done them. The plan is for seniors to complete monitoring." There had been no analysis of accidents and incidents completed since October 2015. The manager said, "I plan to do something similar to what was done previously." Previous analysis looked at the number of falls, where they occurred and whether they resulted in a hospital admission. One comment stated, 'There is clear correlation between all "fallers" in those individuals physical health was relatively complex throughout their stay." There was no information to identify people's physical health needs and how this correlated to the number of falls they experienced. There was no evidence of any lessons learnt through analysis, or any changes in practice other than an indication that the care plan or risk assessment had been reviewed.

People had risk assessments for areas of need such as mobility, medicines and skin integrity. The information contained in the risk assessments was generic and not specific to the individual. The measures to minimise the risk in relation to mobility were recorded as 'adhere to mobility and transferring instruction as per written documentation; support with moving and handling techniques as per policy and procedure; appropriate mobility aids and equipment in situ.' There was no information about the specific equipment the person needed or where the specific transfer instructions could be found.

A fire risk assessment was in place and had been written by the manager on 21 January 2016. It included information that a full evacuation was completed six monthly however there was no evidence of this, other than a night time simulation which had been completed in August 2015.

People had personal emergency evacuation plans (PEEPS) however they contained generic information. One of the questions asked was 'Could you raise the alarm.' The response was 'I would be able to use my buzzer to alert for help and possibly to access the fire alarm as I don't need a lot of assistance.' This was written for people who needed two care staff to support them with mobilising. There was no information on the specific needs of the person such as the need to use a hoist for transfers.

The manager was unable to provide evidence that an emergency contingency plan was in place to support staff with the actions they needed to take in the event of emergencies such as the building being inhabitable or staffing level crises.

Health and safety risk assessments were in place for areas of risk such as using kitchen equipment but they had not all been reviewed in line with the review time frame specified on the document.

Weekly tests and inspections were completed of fire alarms, extinguishers and fire doors. The emergency lighting was tested on a monthly basis and it was noted that some needed to be repaired. The manager said this had been done but we did not see any evidence.

The service had two outbreaks of diarrhoea and sickness in December and January. We asked a domestic staff member about cleaning schedules. They said, "We do have a cleaning schedule I think but it's really word of mouth from when you started." They went on to say, "There's only one domestic on at a time, it's not enough really. We go to handover, tidy lounges and the office, go to the kitchen and do breakfasts then dishes then the toilets and a pull-out on the wings." They went on to say, "We help with dinner and the dishes as well." We asked about procedures during an infectious outbreak and they said, "We deep cleaned

rooms when people moved and used disposable cloths which got put in the clinical waste."

Equipment cleaning monitoring sheets were in place for the hoist, wheelchairs, mattresses, commodes and other equipment. Some equipment was not routinely signed for as being cleaned however it was not clear which equipment was in use and therefore which needed to be cleaned.

These matters were a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

There had been ongoing safeguarding meetings in relation to the service since March 2015 which had produced action plans. Not all actions had been met within the specified timeframe.

The manager said, "We complete a safeguarding consideration log and if safeguarding take it into a strategy meeting we then notify CQC." They added, "Some issues would be notified to CQC immediately."

Between 8 January 2015 and 25 November 2015, 79 safeguarding consideration logs had been submitted to the safeguarding team. Of these, 70 related to individuals and nine to the whole service. These incidents included unsafe admissions into Perth Green House and medicine errors. We asked about these and the manager said, "People have to have capacity to consent to come in. If on admission we find they don't have capacity to consent to the admission we would do a consideration log." Consideration logs had also been completed in relation to medicine errors and medicines being found on the floor.

The manager was asked why there had been no consideration logs completed since 25 November 2015. They said, "I don't know why it stopped." We asked for assurances that there had been no concerns since this time that should have been alerted to safeguarding. The manager said, "There was an admission where the medicines differed on the MARs which will go on the consideration log and there is one professionals meeting pending but I don't know how the alert came in."

There was no information in the safeguarding file to indicate whether or not the consideration logs had been taken into safeguarding strategy. There were no minutes of safeguarding meetings. We asked the manager whether any analysis of the considerations had been completed to identify areas for improvement and were told not. There had been no analysis to assess any trends or procedural failures which needed to be addressed.

People were being placed at risk of potential harm due to the number of incidences and the failure to analyse the incidences to improve the safety of care provided.

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

There had not been any recent recruitment at Perth Green House as there was a long-standing staff team in place. Staff files showed that at the time of recruitment references and disclosure and barring service (DBS) checks had been completed. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The manager explained that it was their policy to renew DBS checks on a three yearly basis. This had not been adhered to and only five staff out of 29 had an in-date DBS check. The manager said, "I am trying to get a handle on it. The change of system means people don't bring their certificate in." Employer's no longer receive a copy of the DBS certificate.

This was a breach of regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations

2014.

The manager explained there were four care staff and one senior care staff member on shift during the day time and two care staff overnight. Rotas confirmed this and all of the staff spoken with except one said there were enough staff to meet people's needs. The staff member who disagreed said, "We could do with a fifth member of staff on the floor, if there's an emergency it can impact on care, especially for people who need two staff." They added, "The seniors will work on the floor if you ask them to and will help." The senior care staff did not routinely spend their time providing direct care to people unless care staff said they needed extra support.

The manager said, "If we had full occupancy we would have five carers. We don't use a formulae but if there were several people who needed two to one support we would increase staffing."

People told us they felt comfortable with the service and had no concerns. One person said, "I feel really safe here, I've no worries about this place."

Requires Improvement

Is the service effective?

Our findings

We asked the manager about staff training and support. The manager showed us a training matrix that detailed the training staff had received and the refresher timeframes. There were gaps in staff training, for example 21% of staff did not have in-date safeguarding adults training or fire safety. Also, 35% of staff needed to attend infection control training and 72% had not attended health and safety training.

We spoke with care staff about the training they had received. One staff member said, "I've done all the mandatory, first aid, food hygiene, fire safety." They went on to say, "I want to do dementia training and I've asked for autism awareness."

Senior care staff write people's risk assessments but it was noted that only two of the four seniors had attended moving and handling risk assessment training.

Care staff told us they wrote people's care plans so we asked if they had received training. One staff member said, "No, not had care plan training, you just pick it up as you go along." They added, "If you're struggling you just look at someone else's and see how they did it." Another said, "No I just picked it up, it's about remembering what to put in it and how to write it so it's person centred. I write it all down so I don't forget." We asked the manager how staff competency was being assessed if they hadn't had training. The manager said, "Senior staff should have had training. I don't know about care staff, they will have had support but no training."

Some people had specific health needs such as catheters and stomas. We asked staff if they had received any training in these areas. One care staff member said, "We've been shown but not trained, we change bags each week and promote people to do it themselves. We've had no proper training." The manager said, "The training needed to be specific to the person so the nurse based here worked with the ward staff to show care staff how to do it." There was no evidence of competency recorded however the manager explained staff were competent as they had attended the training.

We asked staff about the support and supervision they received. Supervisions are regular meetings between a staff member and their manager to discuss how their work is progressing, future training needs, and any issues around the needs of people who use the service. One care staff member said, "It's been a while since I had supervision, before summer, I really can't remember." Another said, "The seniors used to do them and they were regular and thorough but it was taken off them and they don't happen now." We asked about annual appraisals and one staff member said, "I've never had one I don't think." Another said, "Can't remember, before summer maybe."

The manager said, "There's no supervisions or appraisals. [Previous manager] stopped seniors doing them for some reason. I plan to have four teams, each led by a senior and the senior will do them." Staff files confirmed that staff had not had a supervision for at least six months and there was no evidence of annual appraisals. The manager had completed supervision with two senior care staff.

There was no evidence that staff permanently employed at Perth Green House had attended an induction as they had been in post for many years. We asked the manager about induction processes and they said, "There is a corporate induction." We asked if it was linked to the care certificate with gives an identified set of standard skills, knowledge and behaviours for care staff to provide compassionate, safe and high quality care and support. They said it was not.

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

Two agency staff were working at Perth Green House during the inspection. They both told us they had been shown around the building, had gone through the fire procedure and had time to read care plans as their induction. One agency staff said, "The staff are very nice and supportive." The manager had copies of DBS checks and references completed by the agency for these staff.

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

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

Staff understood the meaning of DoLS. There were no capacity assessments in people's care records. We asked the manager about this. They said, "We don't support anyone who has a DoLS, people need to give their consent to the admission. It could be done under a best interest decision for them to come in but they would need the capacity to understand instruction and if they didn't we would request a DoLS." Some people had signed documents to say they consented to the care and rehabilitation they would receive whilst resident at Perth Green House but other people hadn't. We asked if there was an admission framework in place but the manager was unable to provide this.

District nurses were involved with people who had specialised needs in relation to their nutrition and dietary requirements. The cook had access to information about people's dietary needs.

One person said, "It's nice food, you get a choice, we are offered a menu and they fill it in. We get breakfast, lunch, tea and a biscuit for supper." Another person said, "The food is brilliant. I've put weight on since I came here which is good."

A nurse, occupational therapist and physiotherapist were based at Perth Green House and supported people with their rehabilitation. A pharmacist held twice-weekly sessions to review medicines, liaise with doctors and assess how the staff could promote and support people with the administration of their own medicines.

In addition to the external professionals who were based at Perth Green House, people had access to a linked GP practice who visited the service on a weekly basis. The manager explained that people were registered with their own doctor but were often out of area so there was a contractual arrangement with a local practice to provide GP support for people.

The building was quite dated in appearance and the manager said they did not think the baths met people's needs. This was because they had bath chairs in them so it was not possible for people to have a soak; they said people preferred to use a shower. People's rooms were rarely personalised; staff said this was due to the short term nature of the service.

Requires Improvement

Is the service caring?

Our findings

Bathing and showering charts were completed on a daily basis. It was noted that baths and showers were declined on an almost daily basis by people in favour of a body wash. We asked the manager if they had asked people why this was the case. They said, "We've increased the offers to people, sometimes people can get a little irritated with us if we keep asking. You can't force people even if sometimes they are a bit whiffy." The manager added that this was one of the area's being addressed through the overarching safeguarding meetings.

Care documents contained words like 'fallers' and stated 'two carers to put [person] in the shower', the manager referred to rooms which were adapted to meet the needs of people with physical disabilities as being "PD rooms." These group labels did not promote the dignity, respect or individuality of each person.

There was a list of the people who needed to be offered a specific diet and why. This was displayed on the wall near the serving area of the kitchen and dining room. This meant it was visible to anyone so could compromise the privacy and dignity of people using the service.

Care records were stored in a filing cabinet down a corridor known as 'the office wing.' The filing cabinets containing personal and sensitive information about people was not locked, nor was it in a locked room. This area of the building was used by visiting professionals and the therapists who were based at Perth Green House. Any professional in this area of the building could access any person's records whether they were authorised to do so or not. This compromised the confidentiality of people's records.

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

People told us they were happy with the care they received. One person said, "The staff are nice. I'm working with the girls on sitting up and standing, it's not perfect though." They added, "I'm going to speak with the physio as I still get a bit wobbly." They went on to say, "I'm happy with the treatment I get."

Another person said, "You couldn't get better care; they look after me day and night, it's very good." They added, "I've no complaints, no worries. The nurses and physio and the people who do the meds are completely separate to the carers. The carers are spot on."

One visitor said, "The staff are excellent, brilliant." They added, "The staff are very kind in their help and assistance."

One person described the difference in their health since being in Perth Green House and explained their weight had improved. They said, "The work I've done with the staff and the physio is getting me back on track, building my confidence and I'm doing very well."

Perth Green House has four wings, all of which have their own lounge area and small kitchen area so we did

not see people sitting together in the main lounge. Rather people spent time in the smaller lounges watching television or were spending time in their rooms.

We observed interactions between care staff and the people at Perth Green House over lunch time. Care staff were kind and spoke to people with respect and compassion.

We saw one person had their eye drops administered at the tea table whilst they were sitting with other people having a meal. The senior carer asked the person if it was ok to administer them and they said yes.

One care staff member said, "I love to see people going home, it is about satisfaction, you work with people with the physio and get to know people better."

Care staff told us they included input from people in the care plans. One staff member said, "Clients are involved in care plans, I ask them the question, take the plan in and let people read it. I ask what people can do themselves and update it as time goes on." They added, "We don't know what people can do when they come in as they will try to struggle on."

The manager said no one had an advocate. Information was provided to people about advocacy services in the service user guide.

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not contain specific detail on all their areas of needs nor did they specify all the equipment people needed to use. Information on specific strategies which should be used to support people was missing from care plans. Weekly reviews of care plans were completed routinely but they often contained information that contradicted the care plan. Care plans were not updated in response to changing needs which had been identified during the weekly review.

One person had a discharge team assessment which had been completed prior to their move to Perth Green House. This stated that the person needed the assistance of one care staff, with the use of aids and adaptations to assist with getting in and out of the shower. This information had not been transferred to their care plan. There was no detail about the aids or adaptations the person needed. Another person's referral form detailed specialist equipment, such as a specific mattress used for pressure care, but this was not recorded in the care plan. This meant people were at risk of receiving inappropriate care.

One person's continence care plan stated that due to decreased mobility they would require support to and from the bathroom but there was no detail about what support they needed. Staff may have been providing inconsistent care as there was no support strategy detailed.

Several people's care plans recorded that they wore continence aids but there were no specifics around the size or make each person needed to use.

One person had a skin integrity risk assessment which stated the specific requirements for the person's fluid intake. This detail had not been recorded on the person's diet and nutrition care plan. Support plan reviews had been completed on a weekly basis and it was noted that the last review contained contradictory information to the care plan in relation to the person's fluid intake. We raised this with the manager and senior care staff on day one of the inspection and they said they would clarify it. This meant the person was at risk of receiving care which did not meet their needs and which placed their health at risk.

Personal safety care plans stated, 'due to current health concerns and poor mobility and transfers there would be a number of risks that require intervention, these may impact on daily living and the risk of falls.' Other than the mention of a falls risk there was no other information on the risks or the interventions that would be required.

Another person had risk assessments in relation to their personal hygiene needs and specific medical interventions that had been required to care for them. This information had not been included in the person's care plans so unless care staff read the risk assessments they may have been unaware of this person's specific needs.

Due to fluctuating mobility needs, one person had been assessed as needing to use a stand aid hoist, and at another time they required the use of a 'full hoist.' The person's mobility and dexterity support plan had several dated entries on it, one of which was to transfer with stand aid hoist and two care staff but there was

no detail about how to transfer using the hoist. A later entry stated to use the full hoist but again there was no detail about how to support the person. A further entry stated the stand aid hoist was to be used with two care staff, a medium sling and red loops. The mobility risk assessment for the person stated the person was using a full body hoist for all transfers. This meant the risk assessment was not up to date with the care plan so the person may have been at risk of receiving care that did not meet their current needs.

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

A complaints file was in place and it contained one complaint which had been received on 9 February 2015 and concluded on 7 May 2015. The complaints policy stated timeframes should be agreed during the completion of a complaints plan. However we saw no evidence of this.

We asked the manager if this was the only complaint they had received. They said, "No, there's been a couple more which responses have been sent to". The manager told us about the nature and outcome of the complaints however we saw no evidence of the recording of these complaints as they had not been logged.

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

There was no dedicated activities co-ordinator. Care staff said they arranged activities when they could, such as bingo and quizzes. They had organised a race night but one staff member said, "People just wanted to have their chips and go to bed." Another said, "We do a coffee morning and a movie night." They added, "All activities are in house. Family and physio might take people out but it'll be as part of their therapy not as a social event."

People had support plans about daily living and social activities which referred to a daily exercise class and a coffee morning each Wednesday. Posters advertising these events were on display. One person said, "I go to the quiz but there isn't really anything else that suits me." Feedback about activities had been provided on resident questionnaires however there was no evidence to indicate how this had been responded to.

We asked how a person's religious or spiritual needs were met. One staff member said, "The family would arrange a church visit. Sometimes the vicar comes in visits individuals but it's up to families. We do have numbers for churches though."

People told us they had no concerns or complaints. One person said, "It's very good, no complaints at all."

A referral form was in place and was used for any person who was wishing to move into Perth Green House for a period of rehabilitation. This was completed alongside a care management review which was forwarded to the manager. We asked if there was an admission framework for Perth Green House but the manager said not.

Concerns about admissions into Perth Green House had been noted and safeguarding consideration logs had been completed in relation in this. The manager had introduced a system where they reviewed all the information prior to admission and we saw that on occasion they were querying information with the relevant care manager.

The manager explained that a 'huddle' meeting was held on a Monday and a Friday to improve

communication. One care staff member described this as, "A discharge discussion, it helps to prepare people and get staff ready." This was chaired by a nurse who worked in Perth Green House and attended by care staff, the manager and a physiotherapist. The nurse went through each person giving an update on their current needs and progress. This meeting was not minuted so there was no formal record made of any actions or progress. Updates covered people's nutritional and mobility needs, continence and health care. Several people were discussed as being 'ready to go home' although it was noted that they were waiting to be allocated a social worker.

The manager explained there were two social workers linked to Perth Green House to support with appropriate discharge; however neither of them were currently available due to a vacancy and an absence. They said they had been in contact with the team leader and social workers were now being allocated. One staff member said, "Delayed discharge is out of our hands, it's due to the lack of social work involvement. It can prevent people going home when they are ready so they slip back and lose motivation." They added, "We don't always know why it doesn't happen."

A discharge procedure was in place which detailed the information that should be handed over. A checklist was in place, as was a discharge summary document.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection a registered manager was registered with CQC however they had not been in post since July 2015. They had applied in November 2015 to cancel their registration with an effective date of 1 August 2015. The provider had completed a notification to CQC on 14 July 2015 and 30 July 2015 to inform us of the absence of the Registered Manager.

The current manager had been in post for one month and a previous manager had been in post from 1 September 2015 to December 2015. This meant the service had been without a registered manager in post and carrying on the regulated activity for six months.

During the inspection it was noted that the registration certificate for the registered manager who left in July 2015 was still on display.

Perth Green House had been in overarching safeguarding since March 2015, which meant there were concerns about the overall provision of the service. As a result of these meetings the local authority developed an action plan with Perth Green House. The manager shared this with us and we saw that there were several areas of action that had not been met even though the target date for completion was 31 July 2015 or immediately.

The actions identified as having an immediate timeframe included risk assessments needing to be robust and specific to the individual and medicines to be administered appropriately as per prescription. These areas of concern had not been addressed as evidenced during our inspection.

A monitoring visit had been undertaken by the local authority commissioners on 17 and 19 January 2015 which also identified similar concerns. The summary identified key areas for development and key improvement priorities.

We asked the manager about quality assurance and audits. They said, "I haven't done any." We asked about care plan audits and the manager said, "They would be in the file." There was no evidence of any audits in any of the care plan records. A senior carer said, "We did used to do them but they haven't been done for a while now." Another senior said of audits, "There's been lots of upheaval in the office; lots of changes to paperwork and management."

Medicines audits were not being completed other than a stock count which was not effective in ensuring the safety of the administration of medicines. There was no evidence that audits of any records had been completed. The manager said, "We have monitoring visits by commissioning." We asked them if there was an action plan or service improvement plan in place and the manager said, "No, no there isn't."

We asked whether staff surveys had been completed so staff had the opportunity to be involved in developing the service. The manager said, "No, it's not done. We used to do a staff survey corporately but no individual ones have been done." It was explained that it was recent practice as South Tyneside Council not

to undertake staff surveys.

Residents' and relatives' meetings were not held. The manager said this was due to the turnover of people living at Perth Green House. Surveys were provided to people in their welcome pack for them to complete at the end of their stay. A six monthly report was produced based on the feedback results, with the last report dated June 2015. The report identified that 100% of people felt cared for and happy with the therapy and meals, 49% of people said they hadn't been involved in their discharge and only 67% of people said they were given a choice of things to do. People's comments were included in the report but there was no action plan developed in order to respond to comments or improve the service for people.

There was no evidence of any internal quality assurance systems. Audits were not completed and the managers had not used the information available to them from external audits and action plans to complete their own review of the service and develop plans to improve the service.

We asked staff about the culture of Perth Green House. One staff member said, "To be honest with you I feel like we've been pushed from pillar to post there have been so many management changes." They went on to say, "[Manager] has said they are staying till June." This is the point at which the care and support provided by Perth Green House will transfer to the NHS Foundation Trust at which point the current manager post would be deleted as it would be provided by the Trust. They added, "Morale has been really low but it's started to pick up. I'm looking forward to meetings with management to look at strengths and weaknesses, so we can move forward."

One senior care staff member said, "It's been difficult with all the management changes, they all change systems."

The manager was aware of the low morale amongst staff and said, "We are moving to a new building in May/June time." There was no transition plan in place but the manager said, "It's one of the things we need to do as it won't be a like for like service."

Team meetings had been held on a monthly basis until September 2015. An agenda was in place for October but no minutes. The next meeting after that was January 2016. Agendas included safeguarding; supervisions, care plans, training and the local authority inspection report. Senior care staff meetings were also held but there had not been one since July 2015. One staff member said, "Team meetings are every month, last week we had one. They are pretty good, agenda's set by staff."

A range of policies were in place in a policy file. Some, like the complaints policy and the equality and diversity policy stated 'please refer to South Tyneside's council's policy.' These policies were not readily accessible. Staff signature lists were in place for other policies such as infection control, supervision, safeguarding and medicines. However, of the 31 staff named on the lists they had only been signed by between 13 and 20 staff.

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

One care staff member said, "It's lovely here, the team work well together," They added, "The stand-in manager is approachable. There's lots of change, we need to find out what's happening, rota's are up in the air, but we need to wait till the end of February to find things out."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect. The privacy of service users information was not always maintained. Regulation 10 (1); 10(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established or operated effectively to investigate allegations and prevent abuse of service users. Regulation 13(2); 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not an effective system operated for the recording, handling and responding to complaints. Regulations 16(2)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were not receiving appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

There was no systematic approach to determine the number of staff needed to meet people's needs.

Regulation 18(1); 18(2)(a)

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Medicines had not been administered accurately in accordance with the prescriber's instructions. Sufficient medicine was not always available. Staff competency had not been assessed. There was a failure to assess and mitigate the risks to the health and safety of service users. Regulation 12 (1); 12(2)(a); 12(2)(b); 12(2)(f); 12(2)(g); 12(20(i)

The enforcement action we took:

A warning notice was issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established or operated effectively to ensure compliance. There was a failure to assess, monitor and improve the quality and safety of the service which meant risks had not been mitigated and accurate and complete records had not been kept. Feedback from relevant persons had not been acted upon to improve the service. Regulation 17(1);17(2)(a); 17(2)(b); 17(2)(c); 17(2)(e)

The enforcement action we took:

A warning notice was issued