Pressbeau Limited

Greathed Manor Nursing Home

Inspection report

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Ratings

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

Overall summary

Greathed Manor nursing home provides care and accommodation for up to 32 people. The home is a Grade 11 listed building. On the day of our inspection, 29 people were living in the home which included three couples. Many people needed nursing care and/or were living with physical disabilities. Some people were living with dementia. Greathed Manor service user guide states that they provide caring and professional process for those people that are terminally ill.

The inspection took place on the 19 and 22 December 2014 and was unannounced.

A registered manager was not in post. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An appointee manager had been in post since August 2014.

People and their relatives gave mixed feedback about the service they or their family member received. Whilst some people were very happy, others were not. Our own observations, those of health care professionals and the records we looked at were not always in accordance with the positive views held by some people.

People's safety had been compromised in a number of areas. For example, there was not enough staff employed or on duty to meet people's needs. Staff did not have the specialist training they needed in order to keep up to date with best practices issues in the care of people at the end of their life. Poor pressure area prevention care put people at risk of developing pressure wounds.

Unsafe medicines storage and administration arrangements put people at risk of accessing medicines that were not prescribed to them.

Care plans did not reflect people's current needs or individualised choices. They had not been reviewed on a regular basis. This put people at risk of inconsistent and /or not receiving the care and support they need. Assessments of people were not sufficient to make sure the care is planned to meet a person's individual need.

The legal framework around the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards had not been followed. Staff we spoke with did not understand the requirements of the Act and how it affected their work on a day to day basis. The appointee manager had not completed close gap thee necessary MCA two stage assessment or applications to the local authority as required by the Deprivation of Liberty Safeguards (DoLs). Which meant people without capacity had not be supported in agreeing to choices made about their care.

The provider had not ensured there were the right mix of skills, competencies and experience of staff on duty each day to keep people safe.

Staff did not have the specialist training they needed in order to keep up to date with care for people who lived with epilepsy or needed support in end of life care. Staff did not demonstrate best practice in their approach to the care, treatment and support people received.

People were not being effectively supported with their nutrition or hydration needs. Some people were not supported in having regular drinks. This meant they may be at increased risk of becoming dehydrated.

People and their relatives told us that most staff members were caring and trying to do a good job. We observed some both good and poor examples of staff interaction with people throughout our inspection.

The provider did not always investigate record and tell people of the outcome of their complaint.

Some activities were available. We saw some people enjoyed an activity on the day of the inspection. However there were not enough activities provided for people specific to their needs.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, four of which correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Risks to people's health and welfare posed by the care they received and the way the service was managed were not always minimised effectively.

Medicines were not always managed, administered or stored safely.

People were not always treated with dignity and respect.

People were deprived of their liberty without the appropriate safeguards in place.

Staff knew how to keep people safe and protect them from abuse. They reported their concerns to the manager or a senior staff member and relied upon them to take the necessary action.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported to receive adequate nutrition and hydration.

Staff were not effectively monitoring people's healthcare needs, particularly when their needs changed.

Staff did not have the skills, knowledge and experience to meet people's needs.

Staff did not understand their responsibilities under the Mental Capacity Act 2005. Some people's freedom were being restricted without their rights being protected and there was not a system in place to identify if people could make decisions about their care and treatment.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people we spoke with were positive about the care they received, but this was not always supported by our observations or those of visiting health care professionals.

People's privacy and dignity was not always respected by the way that care was provided.

People's end of life wishes were not consistently recorded or acted on.

Is the service responsive?

Requires Improvement

The service was not responsive.

Summary of findings

Care records were standardised across the service with no evidence of person centred care.

People's care needs had not been reassessed to sufficiently guide staff on their current care.

Although people were encouraged to raise their concerns or complaints, one relative told us their complaints were not listened to.

Whilst staff were aware of people's preferences, they were not always able to ensure that care was delivered in a timely manner that met people's needs.

Information gained to develop a plan of care to meet a person's needs was inadequate.

Is the service well-led?

Requires Improvement

The service was not well led.

The service has not had a registered manager in place since August 2014.

There was a poor culture at the service. Staff felt they were not listened to and were blamed when things went wrong. People we spoke with told us that leadership was improving.

Staff had not received regular supervisions or appraisals.

The appointee manager had not always ensured that effective systems were in place to identify and remedy areas of concern.

Greathed Manor Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was carried out following concerns raised with us by the local authority's safeguarding team. At the same time we had received separate concerns about the service which raised issues upon the quality of care that people received. On this occasion we did not ask the provider to complete 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 improvements they plan to make. This was because we were responding quickly to information and concerns that had been raised with us.

The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone, who uses this type of care service.

During the inspection we spoke with eight people who lived at Greathed Manor, eight staff, three relatives, the manager, and one health care professional. We observed care and support in communal areas and looked around the home, which included people's bedrooms, the different floors within the building and the main lounge and dining area.

We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We looked at a variety of documents which included seven people's care plans, five staff files, training programmes, medicine records, four weeks of duty rotas, maintenance records, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the appointee manager to send us some additional information following our visit, which they did.

The last inspection was undertaken on the 5/09/2013 where no concerns were noted.

Inadequate

Is the service safe?

Our findings

One person said they felt safe because staff slept on site although told us "At times I have to wait for staff" they added, "The home is short to being short staffed. Sometimes I have to wait 10 minutes but that doesn't happen often." A relative said "There is not always a staff member in the lounge when residents are there."

There was not always sufficient staff on duty to be able to meet the needs of people. We saw that call bells were constantly ringing, often going on to the emergency alert as they were not being answered promptly. Staff told us they were very busy which we saw for ourselves.

One person said, "I've waited 20 minutes for a response to the call bell" and "The response to calls at night is slow". A relative told us about their concerns when call bells are not responded to quickly commenting: In a mild way there is abuse by neglect by taking too long to respond to a call". The appointee manager said calls bells should be answered, "In three minutes." The electronic call bell log for the day of our inspections showed that staff responded to calls in a variety of times the average time approx. six minutes. The call bell log from the 11 December to the 19 December showed that call bells were not always responded to in a timely manner the longest response taking 21 minutes.

One staff member told us they had not read any care plans because there was not enough

time. Another told us they had no time to sit and speak with people or to effectively support them. One staff member described that during the afternoon a person had needed support with personal care from two care staff members. They said at the same time another person needed support from two members of staff which meant that the needs of other people were not being met. We saw an example of this later in the afternoon; we observed four staff called away to support the needs of two people which meant that the other people in the home had no direct staff support for approx. 20 mins.

One person said, "I think they are short staffed, especially at weekends". A relative told us, ""The staff change a lot here". One staff member said, "Staffing levels always met the minimum – one nurse, five care staff in the morning – even at weekends". During the afternoon there are only four care staff on duty. One relative said, "There is not always a staff member in the lounge when residents are there". We saw that in the morning people who were sitting in the lounge had to wait for a staff members to bring someone else into the lounge so they could ask for assistance, or relied on visitors to find staff members for them.

Staff said mornings were pressurised because of insufficient staffing levels and the needs of people. Breakfast was between 7.30 and 8.00am and everyone had breakfast in bed, then staff started getting people up. Some people liked to get up later, but some people ended up being in bed quite a bit later than they wanted to be. One person said "It's 11:40, I wanted to get up and dressed much earlier than this." Evenings we were told by staff were less pressured. Between 3.30pm and 5.00pm there was sometimes time to talk to people. One member of staff said, "We need to give excellent care, but need two nurses. It may take up to an hour to do a dressing, so sometimes people have to wait." They told us they had asked the appointee manager for more staff. Another member of staff said, "I am aware of people having to wait, it's quite stressful and today one person hasn't got out of bed until almost lunchtime." They added, "Staff deal with situations here quite well, even if we are short staffed."

The nurse we spoke to said that each day was very busy; they felt that the nursing needs of people could not always be met. They said dressings for people were rushed. Sometimes people did not receive their 8am medicines until lunchtime and that they did not have time to check charts in place to support people's needs. They said that they felt one nurse to support 29 people with high dependency needs was not enough.

The appointee manager said they did not have a process for assessing the dependency needs of people and how this reflects on the amount of staff needed. They also said they were in the process of recruiting more staff. We asked the appointee manager to tell us how they were going to address our concerns about insufficient staff the on duty to meet the needs of people. The appointee manager said this would take effect from the 26 December 2014.

There were not enough staff to meet the needs of the people who lived in the home. This was a breach of Regulation 22 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social care Act 2008(Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Not all the practices we observed were managed safely. We witnessed on two separate occasions a person slipping onto the floor from a wheelchair during lunch time. The person had raised their hand to call staff for assistance however staff did not respond in a timely manner and the person slipped from their wheelchair. Three members of staff were involved in the manual handling procedure to support the person to rise from the floor and the appointee manager had to intervene as staff were unsure of best practice techniques. A second incident happened 45 minutes later. We spoke to the appointee manager about the incident and were told the physiotherapist had assessed that the person's wheelchair was not suitable for them and that an alternative chair should be sought. This had not happened and the appointee manager had not implemented strategies to reduce the risks to the person whilst they were sitting in the wheelchair.

This also impacted on other people in the dining room as there was not enough care staff supporting others. One person was standing up from their place to allow staff access and two others, who were being supported to eat, had to sit and wait for their meal.

We saw staff pushing a person in wheelchair without the lap belt fastened. The staff member said, "Sorry I was rushing". This meant the person was at risk of falling out of the wheelchair whilst in transit. Best practice guidance from research carried out by the **Social Care Institute for Excellence (SCIE)** when the wheelchair is in motion, the lap belt would be used to prevent the resident from slipping out. However, once the resident had reached their destination, they would be encouraged to transfer to another chair.

Four people had been identified as a risk of developing pressure ulcers, their pressure relieving equipment were all set to the highest level, and did not reflect the person's current weight. This put the person at increased risk of developing pressure ulcers. NICE (National Institute for Health and Care Excellence) Guidelines CG 179 for the prevention and management of wounds was not being followed. If the appropriate equipment was used incorrectly it would increase the person discomfort and risk of further deterioration to wounds and skin integrity.

Assessment of the risk of a person falling from bed had not been undertaken. The assessment should have considered whether bed rails are the appropriate means of managing that risk. For example, if the person is likely to try to climb over the rails due to confusion, then other control measures (such as extra-low beds and/or sensor alarms) may be more appropriate. Where bed rails were fitted, care staff needed to be aware of the risks and how to ensure the persons safety. Information on whether bed rails are used should be included in the persons care plan.

Four people had bed rails without protective bumpers on and were at potential risk of injuring themselves or from entrapment. Bedrails are used to reduce the risk of falls from beds and protective bumpers reduce the risk of entrapment to the person. By having no bumpers people were at the risk of entrapment.

People were not protected against the risk of receiving care or treatment that was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Following the inadequate nursing practices observed we were informed by the provider of immediate steps taken to prevent this occurring.

We observed some practices which did not safeguard people from the risks of safely being supported to take their own medicines. We observed lunch time medicines being administration and found the nurse dispensed medicines from blister packs into individual pots. They did this after checking the Medication Administration Record (MAR) chart for each person. However, they did not check the person took their medicines before signing the MAR chart to confirm they had administered the medicine. The medicines were stored in a trolley which the nurse locked each time they left it. The room temperature was checked and logged and was within the required range to help ensure that medicines were stored at the correct temperate to remain fit for purpose.

Two people did not have photographs on their cover of the MAR chart. This posed a potential risk that someone could be identified incorrectly and given the wrong medicine. Particularly when agency staff were working and they would not know what a person looked like.

One person was given medicines at 1.00pm, but the nurse did not sign the MAR chart to show that it had been given; this was still not signed at 3.15pm. This meant that other staff may think the medicines had not been given and put the person at risk by administering a second dose of medicines. Two people's as required medicines (PRN) sheets were within someone else's section in the medicines

Inadequate

Is the service safe?

folder. One person's medicines were left on their table in their room during lunch, but the nurse did not check the person took them. We asked staff about this and were told, "Some people like to take their medicines slowly with food. I come back and check they have been taken." However, at 2.30pm we noted this person had still not taken their 1.00pm medicines. We saw the medicines and dispensing pot were no longer with the person at 3.15pm and checked the MAR sheets, but they were still not signed. There was no risk assessment about leaving medicines out. The person experienced short term memory loss and by the nurse not supporting the person to take the right medicines at the right time could have a detrimental effect on the person's health.

The appointee manager told us the local pharmacy was carrying out a training sessions for all nurses on 15 January 2015. They also told us there had been a recent medicines audit carried out by the pharmacy, which had identified no actions.

Not all medicines were stored of or disposed of safely. Food supplements, dressing packs and fluid thickeners were stocked in a room which was not locked. The cupboards within the room were not locked. The room was freely accessible to people. We also noted in another unlocked area eight large boxes of medicines waiting to be returned to the pharmacist that was not stored safely.

Some of the medicines were dated the 4 November 2014. We asked the nurse why these medicines had not been logged as returned or destroyed and were told, "I have not had time". As these medicines were not stored securely there was a risk that medicines could be removed and therefore not be available for people and/or taken by someone accidentally. .

We found that medicines were not stored, administered or disposed of safely. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) & (g) of the Health and Social care Act 2008(Regulated Activities) Regulations 2014.

Staff recruitment files contained a check list of documents that had been obtained before each person started work. Staff said they had to provided two references, filled in an application form and have a Disclosure and Barring Service check (DBS). Staff files contained evidence of health checks, references, photographic identification, completed application forms and DBS's. The nurse had provided evidence of their registration however we read this expired in September 2014. We spoke with the nurse and appointee manager who both confirmed the new registration certificate was with head office and would be inserted into their personnel file once received.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff said that they would feel comfortable referring any concerns they had to the manager or the local authority if needed. There was a Safeguarding Adults policy and 21 staff out of 28 had received and passed the providers arranged training for safeguarding adults. One staff said they would have, "No hesitation in whistleblowing" if they suspect any abuse going on.

We checked that equipment had been serviced regularly to help ensure it was safe to use. Hoists seen were last serviced in April and October 2014 and fire extinguishers were last tested March 2014. This showed that care staff should ensure there are adequate systems in place for maintenance and inspection of hoists and slings in line with the manufacturer's instructions,

The appointee manager told us the local pharmacy was carrying out a training sessions for all nurses on 15 January 2015. They also told us there had been a recent medicines audit carried out by the pharmacy, which had identified no actions.

Inadequate

Is the service effective?

Our findings

Two people said, “We are not aware of a care plan." Relatives we spoke to said, “For a whole week in July, records in my relatives care plan went missing” and “Mostly the carers are quite sweet but they don’t go the extra mile”.

People were not sure whether all staff had the right skills and training to fully meet their needs. Staff did not receive regular supervision and annual appraisals. The staff files we read indicated staff did not receive appraisals. This was confirmed by the appointee manager who told us they had started this in January 2015. One staff member had last received supervision in May 2013, another February 2013 and another April 2013. Staff meetings and supervision meetings give staff an opportunity to talk through any issues of concern about their role, or about the people they provide care and support to.

Staff said they shadowed more experienced members of staff when they started work at the home. They told us they worked in pairs for people who required more complex care. An agency member of staff said they had received an induction, by working with a senior member of staff, when they first worked in the home so they knew about the care needs of people. They told us staff always worked as a team.

A member of staff told us, “We need to do more training. We need to be kept updated with new guidance.” The staff training plan showed that staff had not completed the necessary areas of training to ensure they were suitably skilled; 21 staff out of 28 had not completed the Common Induction Standards training (**Common Induction Standards** (CIS) are the standards people working in adult social care need to meet before they can safely work unsupervised). Subsequent to the inspection the provider said that some staff had previously attended this training but evidence to confirm this was not available on the day of the inspection.

Greathed Manor service user guide states that they ‘provide caring and professional process’ for those people that are terminally ill. The training plan showed that none of the staff had received training in end of life care or in equality and diversity. This meant that staff would not be aware of the most up to date guidance in relation to the care being provided to people.

Some people had been assessed as being at risk of developing pressure ulcers. We noted that four people had wounds. The records contained no information to show the size or depth of the ulcer or the treatment required. Consequently, from the records it was not possible to establish whether the ulcer was healing or deteriorating. We spoke to the nurse in charge and they said that “I have not had specific training in wound management or pressure area care and prevention”. This showed that the provider had not followed the guidance set by NICE in CG 179 which states ‘Training to healthcare professionals should be provide on preventing a pressure ulcer, including: who is most likely to be at risk of developing a pressure ulcer, how to identify pressure damage, what steps to take to prevent new or further pressure damage, who to contact for further information and for further action. Training should include: how to carry out a risk and skin assessment, how to reposition a person, information on pressure redistributing devices, discussion of pressure ulcer prevention with patients and their carers and details of sources of advice and support’.

Staff did not always receive the appropriate support through training to be able to meet the range of people’s needs effectively. These are breaches of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People had a choice of where to have their meals either in the dining room or their own room. Staff told us most people had their breakfast in their rooms. However, people did not always have access to adequate food and drink. People gave us mixed feedback about the quality of the food. One person said, “The food is OK, we get a choice” and “We order our meals on the day before” and “They will do something else if we don’t like the menu”. Another person said, “The meals are pretty good and there is an adequate amount to eat” and “We get plenty to drink”. The third person said: “Lunch was mediocre and sometimes it’s not nice”

In the dining room four staff served lunch to 17 people. Other people ate lunch in their rooms. The lunch took one hour to serve. One person waited 25 minutes for the main course although it was the same meal as everyone else.

Inadequate

Is the service effective?

The person was at the table before others had arrived and was one of the last to be served. People were getting impatient and staff were not effectively reassuring or informing people about the delay in serving lunch.

People in their rooms had jugs of water and glasses on their bedside tables however these were placed out of reach of people. One person was in bed and their drink was out of reach and they asked for help to reach it. The person asked if they could have a drink We checked the fluid chart's for this person and found that they had not been supported to take regular fluids. The person's care plan said that when they were admitted to the home they had 'dark urine and low output' and stated care staff were to encourage fluids. The daily notes showed the person had been left alone for periods of up to 6hrs and therefore did not have fluids, nutrition or turned as appropriate. We spoke to one staff member who told us they "had not had time" to undertake the regularly checks required. The nurse in charge stated she had not checked these actions had been undertaken. According to the fluid records available the person's fluid intake varied between 100 millilitres (mls) and 670mls a day. The recommended guidelines from the Royal College of Nursing, Water for Health Hydration Best Practice Toolkit for older adults is that daily intake of fluids should not be less than 1.6 litres per day. The appointee manager told us that this was down to poor recording by staff. However, due to our own observations we were not satisfied that this was always the case. This person had not been assisted with adequate nutrition or hydration. We checked three other people's fluid intake charts and noted that the maximum fluid intake per day was 950ml. Where records had been completed there were often large gaps in the recording and it was rarely recorded if someone had been offered and subsequently declined food or fluid.

We saw that staff had not supported one person who was receiving end of life care had not been offered anything to eat or drink from 7.30am until 2.15pm. Their lunch was a bowl of custard. At 4.15pm the bowl of custard was still on the person bedside table. Staff had been called away and not supported the person to eat or offered an alternative. The relatives we spoke to said that the person did not like custard and asked staff if they could have ice cream and yoghurt. The person was not taken this alternative food for another half an hour. The food and fluid record chart showed this was the only food given to the person in 24 hours. The food chart for this person showed that that on the following day they had only been given lunch throughout the day at 3.30pm. The person's care plan for nutrition stated that they required assistance with eating and drinking. One relative said "The drinks consumption is not checked".

People had not been protected from the risks of inadequate nutrition and dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty safeguards (DoLs) which applies to care homes. Deprivation of Liberty safeguards (DoLs) are part of the Mental Capacity Act 2005. They aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom. Many of the people living in the home were living with dementia. Some had the mental capacity to make their own decisions on a day to day basis, but sometimes this fluctuated. Other people did not have the mental capacity to make their own decisions. Staff had not undertaken training in the Mental Capacity Act (MCA) 2005 they had little practical knowledge of it. For example, staff did not know who was able to make decisions for people who lacked the mental capacity to make their own decisions. It was clear that they misunderstood 'mental capacity assessment' for what was the 'pre-admission assessment' process. Following clarification of what the discussion was about the member of staff informed us that they did not get involved in the assessment of capacity and that this was completed by nurses and management only. The nurse in charge told us it was their responsibility to assess a person's capacity. Consequently, we could not be sure that decisions were being made in accordance with the law and people's rights to make decisions were being protected.

Suitable arrangements were not in place in any of the care plans we looked at for obtaining consent to care or treatment from the person or the consent of another person who is able lawfully to consent to the care and treatment on that person's behalf i.e. A person with Lasting power of Attorney. We did not see any two stage mental capacity assessments, these assessments help determine if a person lacks capacity to make a particular decision. We

spoke to the appointee manager who stated that no deprivation of liberty safeguards (DoLs) had been submitted to the local authority and individual mental capacity assessments had not been undertaken.

We looked at one person's care file dated 1/11/2014, we asked the nurse in charge confirmed the care plan was up to date and complete. The care plan stated that the person had moved into the home in August 2014. The care plan which had not been written until November was inconsistent. The section on communication stated the service user was unable to verbally communicate and "refer to best interest and mental capacity". The capacity and mental state section stated "needs capacity assessment". A capacity assessment had not been undertaken. The care plan had not been completed for sections in relation to memory, mood, anxiety or response to care intervention. The plans of care referred to the Mental Capacity Act 2005 but did not show how the person could be supported in making decisions about their day to day needs or care received.

Three people's care plans had showed that they had been assessed for the need for bed rails the assessment and document 'permission to use restraint' had not be completed or signed by the person, person's legal representative or staff who had identified the need. This was a decision made that limited people's rights without the appropriate assessment of capacity for that specific decision. There was no evidence that a best interest meeting had been held or why the decision for bedrails to be used had been made in the person's best interest.

Where people did not have the mental capacity to consent the provider was not acting in accordance with legal requirements. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had access to a range of health care professionals, such as physiotherapist, chiropodist, opticians and doctors. People said, "They do provide a chiropodist or a dentist if you need it" and "The doctor visits and you can see him if you need to". Another person said, We have a visit from the chiropodist every six weeks" and "We haven't seen the GP, although we haven't asked yet, but would like to."

Health updates and outcomes from visiting healthcare professionals were not always recorded. One member of staff told us they had called the GP to come in to see one person. We observed the GP calling around lunchtime. However, we found no record of the request to call the GP written in the communications book which was used by all staff or the outcome of the GP's visit and advice given. We read evidence in people's care plans of outside agencies involvement with people, such as Speech and Language Therapy (SALT), chiropodist or GP.

Requires Improvement

Is the service caring?

Our findings

One person said “Generally the staff are kind but they don’t have time to chat." During the afternoon we saw some interactions between staff and people, staff took the time to listen and interact with people so that they received the support they needed. People were relaxed in the company of the staff, smiling and communicated happily often with good humour. A relative said they thought the staff were caring and had no feeling that they were disrespectful or not caring to their family member.

There was general praise for the staff and acknowledgement that most staff members were trying to do a good job but were short of time. One person said, “The staff are very nice people, we are lucky” and “The staff know our names, its first names” and “To me you can’t fault them, they are very good” and “They did ask if I was OK."

We saw positive interactions between staff and people. We observed a person being moved using a hoist in the communal lounge. Staff explained the process and constantly asked the person if they were comfortable. Two staff members came into the lounge and chatted with people cheerfully, displaying kindness and compassion. They spoke with people individually and assisted them if they needed anything. Staff who did engage with people knew them well and were able to refer to their likes and dislikes in general conversation to which people responded positively.

We observed lunchtime in the lounge was disorganised and resulted in a poor experience for many people. Two main course choices were available with desserts and it looked and smelt appetising. Meal choices were offered to people even though they had made a choice earlier. People started coming in to dining room between 12.50pm and 1.25pm. People were being given their meals at different times which were sometimes served in a chaotic way. We saw the chef put fish and chips on plates with their bare hands, rather than using thongs, which was not hygienic. The kitchen assistant was heard saying to one person who was anxious, “Just calm down.”

Some people felt their privacy and dignity was respected. During the inspection staff knocked on doors and waited to be asked to come in. People told us “The staff always knock before they come into my room” and “They do treat us with dignity and respect” “Visitors are made welcome at any time but the main door is locked at night” and “They invite relatives to stay for lunch”. One person expressed to us that they had not been given a choice in having a male or female carer and they would have preferred to have a female care staff attend to personal care needs.

A health professional who was visiting expressed concerns over some of the clinical practices / nursing standards they had seen and they gave an example: they had attended a person that had advanced dementia, the nurse had gone into the room pulled the bed covers back and started poking the person legs saying “look they’re swollen”, subsequently the person screamed. The GP felt that this bedside manner of the nurse was unacceptable and that they had not treated the person with respect or dignity. This demonstrated that not all people were treated with dignity.

We asked people and family members if they had been involved by the staff in their care or the care of their relative and they were not always included and kept up to date by the appointee manager and the staff at the home.

Two people stated they had not seen their care plans or been asked their preferred choice in aspects of care. The purpose of the care plan is to find out what the person's needs and circumstances are, and what support they may require. People and their carers should be fully involved in assessments and the planning of any care and support that follows. The person seeking support should be at the centre of the decision-making process that determines how their needs will be met. This approach is referred to as personalisation, which aims to put people at the centre of their own care, giving them independence, choice and control over the services they use.

Requires Improvement

Is the service responsive?

Our findings

One relative said, ""The care is not entirely person-centred".

People's needs had not always been appropriately assessed before they moved to the home. The provider's service user guide states that 'An initial care plan will be agreed prior to your admission and this will be reviewed within two days'. We saw that one person had moved into the home just prior to the inspection. They had not had a completed pre admission assessment carried out and their care plan had not been completed. Without an assessment of someone's needs prior to moving to the service the appointee manager would not know that the person's needs could be safely met. On the day of our inspection another person had been pre assessed by the nominated individual the assessment did not contain sufficient details to determine whether needs could be met or guidance for staff as it did not identify risks or individual needs. The person moved into the home that evening. People who use services should have safe and appropriate care, treatment and support because their individual needs are established from when they are referred or beginning to use the service.

Three days after their admission the person did not have a care plan in place. We spoke to staff who said they were not aware of this person's needs preferences, choices likes or dislikes. The appointee manager told us she had asked the nurse on duty over the weekend to complete the care planning documentation and risk assessments and this had not been done. This meant staff members did not have the appropriate information so that consistent and personalised care could be provided.

There was lack of detailed personal history in people's care plans, to help enable staff to understand and talk to people about what and who was important to them.

Assessment information including information regarding people's communication, skin integrity, personal safety and mobility, mental state and cognition, breathing, eating and drinking, personal hygiene, pain and culture and social interests was not up to date or reflective of the person's needs. One person's care plan stated that the person was at risk of pressure wounds and had areas on heels and right elbow identified at high risk; however no intervention had been actioned. The care plan stated that the person should be turned two hourly. There was no turn chart in place to show that this had happened. There was no wound management plan to help ensure the person was receiving the appropriate care. The person had a pressure wound on their foot. The care plan stated that skin should be assessed every day however there was no record of this happening in the daily notes.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had not been maintained. This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We saw that a person's catheter was caught under their leg and was not draining freely and could cause discomfort to the person. The daily notes said that the person was prone to urinary tract infections (UTI) and the daily notes from the 17/12/2014 stated that the person's urine was concentrated and cloudy; this could be a sign of infection. Nice guidelines for urinary catheters states that drainage bags should be below the level of the bladder and unrestricted. Staff had not received specialised training or guidance in supporting people who had a urinary catheter.

In three of the seven care plans we looked at medical history, communication assessment, monthly updates, personal care needs, falls risk assessment, likes, waterlow (an assessment that identifies the risk to the person of developing a pressure wound), nutrition risk assessment and weekly weight as per guidance were complete and updated in November 2014.

There was a formal procedure for receiving and handling concerns. A copy of the complaints procedure was clearly displayed in the home and was given to people and their relatives when they moved into the home. Complaints could be made to the appointee manager or to the provider. We saw examples of complaints that had been addressed. Not everyone we spoke with said they would be confident raising a complaint. One person said "I have complained but not always had a reasonable outcome". Complaints information was not always comprehensive. We read that four complaints had been received since August 2014, however the appointee manager suspected there may have been more prior to her starting which she could not find. We read that complaints had been

Requires Improvement

Is the service responsive?

responded to; however we noted that not all of the information relating to the conversations held with people or action taken were recorded in the complaints folder. The appointee manager told us she would address this.

Staff were welcoming to family, friends, visitors and pets. The appointee manager told us that they have a dedicated activities person who works four days a week. We saw the activities person interacting with people on a one to one basis. During the afternoon a musical entertainer came and most of the people in the lounge joined in. Staff said there were always activities going on and people were encouraged to participate.

Requires Improvement

Is the service well-led?

Our findings

We received mixed feedback about the management of the home from people and relatives. One person said, “The management seems fine on the basics”. Another person said, “The manager is not a disciplinarian but they get on with everyone”. One relative told us, The management hasn’t changed since the new manager arrived” and “Mum was due to move downstairs yesterday but it didn’t happen till today. It was a communication issue”. A second relative commented, “Things did get worse, but are getting better.”

Several serious and widespread concerns referred to throughout this inspection report had not been identified and been allowed to continue unchecked. There has been no registered manager at the home since August 2014. The appointee manager told us they will be applying to become registered with CQC. At the time of this report no application had been received.

One new member of staff said staff seemed pleased the new manager was on board. They often saw them about the building. Another said, “The manager is excellent, very understanding. There has been a lot of improvement since she’s been here. The deputy is also very experienced.”

A culture of blame and avoidance of responsibility had taken hold. When we discussed our concerns arising from the inspection with the appointee manager the blame for any failure was placed with nursing staff. We were informed after the inspection that one staff member had been dismissed. The manager did not consider contributing factors as to what had prevented tasks being completed satisfactorily, whether there more effective ways of working or their own level of responsibility.

We spoke with one staff member who told us, “Things have vastly improved with the new manager. It was getting really bad before.” They added, “The staff are very nice and really, really good.” They went on to say the atmosphere in the home was much better and they could feel it as soon as they walked through the door. They said "Staff seem happier."

The staff files we read indicated staff did not receive appraisal. This was confirmed by the appointee manager who told us they were started this in January 2015. One staff member had last received supervision in May 2013, another February 2013 and another April 2013. This meant the appointee manager did not have oversight of staff and monitoring their performance.

Some regular audits had been undertaken by the appointee manager. For example: Catering audit two-monthly, health & safety, infection control, legionella/ water temperature, call bell system, and meal time experience had been undertaken on a monthly basis. Most actions identified had been addressed.

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report about inappropriate or unsafe care and support. In relation to care plans that needed reviewing, staffing training, pressure area prevention and the Mental Capacity Act 2005. For example; If regular care plans audits had been undertaken they would have identified the lack of appropriate reviews. Monitoring of daily records would have identified that some people were not being supported to take adequate food and fluids would have reduced the risk to people.

There was not an effective operations systems to regularly assess and monitor the quality of the services provided These issues represented breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

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 18 HSCA (RA) Regulations 2014 Staffing **People who use the service were not supported by adequate staffing numbers to ensure that their needs were met. Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use the service were not protected from risks associated with medicines because appropriate arrangements were not in place to ensure people's medicines were stored correctly or administered promptly. Regulation 12**

Regulated activity	Regulation
	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People who use services were not protected from the risks of malnutrition because they were not always enabled to eat or drink sufficient amounts for their needs. Regulation 14**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People who use services could not be assured that accurate and complete records were held in respect of the care and support they received. Regulation 17**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use the service did not receive care that met their needs or ensured their welfare and safety because people's health, care and social needs were not met. Regulation 9 (1)(a)(b)(i)(ii)(iii)

The enforcement action we took:
We have sent a warning notice to the provider notifying them that they are failing to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010). We have told the provider they are required to become compliant with the regulation by the 9 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People who use services were not protected because the provider did not act in accordance with legal requirements relating to consent. Deprivation of Liberty Safeguard applications to the local authority had not been made in all cases. Regulation 18

The enforcement action we took:
We have sent a warning notice to the provider notifying them that they are failing to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010). We have told the provider they are required to become compliant with the regulation by the 14 February 2015.