New Century Care (Colchester) Limited

The Oaks Care Home

Inspection report

15-25 Oaks Drive
Lexden
Colchester
Essex CO3 3PR
Tel:
Website:

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Ratings

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

Overall summary

This unannounced inspection took place on the 16 December 2015 in response to information of concern we received from a variety of sources.

We found at this inspection that people's safety had been compromised in a number of areas. This included the management of people's medicines, the monitoring of people at risk of and support for people with pressure ulcers, care and support for people with indwelling catheters and monitoring and support for people with their food and fluid intake.

Staffing levels were insufficient to meet the needs of people who used the service. The provider did not have a system in place to ensure continuous assessment of staffing levels to make the changes required when people's needs changed. There were no nurses directly employed by the provider. All nurses were employed through nursing agencies. There was no clinical lead in post with delegated responsibilities and oversight of nursing tasks and assessment of nursing competencies.

Summary of findings

There was a lack of regular safety audits of medicines management within the service. This had resulted in medicine administration errors not being identified and no action taken to mitigate risks and protect people from the risk of harm.

In response to our concerns identified at this inspection we issued an urgent action letter on the 16 December 2015. The provider in response sent us an action plan which told us what action they would take in response to our concerns to mitigate the risks to people's health, welfare and safety.

The Oaks care home provides nursing and personal care with accommodation for up to 61 people, some of whom required specialist palliative (end of life) care. On the day of our inspection there were 53 people living at the service.

There was a registered manager. 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.

Staffing levels were insufficient to meet the needs of people who used the service. The homes manager worked shifts to cover the rota. There was no member of staff delegated to carry out the role as clinical lead. There were no qualified nurses employed directly by the provider.

We found significant concerns in relation to medicines management. People were not receiving their prescribed pain relief medicines as required. People did not always have access to medicines due to staff not managing stock effectively and stocks of medicines ran out. There were insufficient numbers of trained staff available to administer medicines and excessively long medication rounds. Medication audits were poor and did not identify errors. Poor auditing meant that stock did not always balance and discrepancies were not identified by the provider.

There was also a lack of systems and auditing of the cleanliness of the environment and maintenance of the building. We found poor infection control practices and areas of the service which were not acceptably clean. There were strong odours throughout the service and the carpets and furnishings found to be dirty.

People were not supported to access personal care. Some people were found not have been supported with a bath or shower for up to three months. People were observed to look unkempt and have nails which had not been cared for and supported to clean.

The service was not well-led. There was a lack of clinical governance. The registered manager was not a trained nurse and the post of deputy manager where previously this person would have been the clinical lead had been vacant for several months. There were no clinical audits in place which would have identified the shortfalls we found at this inspection. We were therefore not assured that action was taken to identify and mitigate the risks to people's health, welfare and safety.

There were no effective systems in place to monitor effectively and proactively the quality and safety of the service provided. The provider failed to operate effective systems and processes to make sure they assessed and monitored the quality and safety of the service on a regular basis. The environment and equipment for people was not suitable to support people safely and ensure people's individual needs were met.

The provider did not have a robust system in place to evidence their response and outcomes following investigations into people's concerns and complaints about the quality of the service provided.

During this inspection we identified a number of breaches 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 the report.

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

The service 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.

Summary of findings

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People's medicines were not managed safely. We could not be sure people received their medicines as prescribed.

People had been put at risk because staffing levels were insufficient to meet people's needs. There were no directly employed nursing staff. This resulted in a lack of consistent care for people and poor communication in responding to risks to people's safety and health care needs being met.

Risks associated with the use of pressure relieving equipment, and the use of bedrails had not always been assessed and guidance was not provided for staff in the correct use of equipment

Standards of cleanliness were poor. There was a lack of audits and systems in place to maintain safe and appropriate standards of hygiene.

Is the service effective?

Inadequate

The service was not effective as people did not receive care that was based on best practice. Not all staff had the required skills and knowledge to protect people from the risk of dehydration, malnutrition, pressure ulcers and care for people with indwelling catheters and at the end of their life.

There was a lack of effective communication and inconsistencies in how health care needs were met. This placed people at risk of not receiving the health care support they required.

People at risk of malnutrition and dehydration were not sufficiently monitored to mitigate them from the risks of receiving inadequate nutrition and hydration.

Is the service caring?

Requires improvement

The service was not consistently caring. People's individual personal care needs had not been appropriately assessed and their wishes and choices not responded to.

Is the service responsive?

Inadequate

The service was not responsive. Care plans did not contain enough information about people's needs for staff to deliver responsive care.

The provider did not have a robust system in place to evidence that people's concerns and complaints had been responded and action taken to learn from incidents.

Summary of findings

People did not have their individual needs, wishes and preferences adequately assessed in relation to their interests and hobbies and how these could be supported and provided for.

Is the service well-led?

Inadequate 

The service was not well led. There was a lack of clinical governance.

There were no effective systems in place to monitor effectively and proactively the quality and safety of the service provided. The provider failed to operate effective systems and processes to make sure they assessed and monitored the quality and safety of the service on a regular basis.

The Oaks Care 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.

This inspection took place on the 16 December 2015 and was unannounced. The inspection team consisted of three inspectors including a pharmacy inspector and a specialist nursing advisor with specialist experience in wound management and end of life care.

During our inspection we spoke with nine people who lived at the service, four relatives, four agency nurses, five care staff, the manager and area manager.,

We carried out observations of the interactions between staff and the people who lived at the service. We also used the short observation framework tool for inspections (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Prior to our inspection we spoke with stakeholders including commissioners of services. Prior to, during and following our inspection we spoke with two healthcare professionals. We reviewed information available to us about the service, such as statutory notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed information of concern received prior to our inspection regarding the care and treatment of people who lived at the service.

We reviewed care records for four people and examined daily care records for a further 10 people. We also reviewed records in relation to medicines management, staff rotas, staff training matrix and other care records related to the quality and safety monitoring of the service.

Inadequate

Is the service safe?

Our findings

During the inspection our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Medication records did not confirm that people were receiving their medicines as prescribed. When we compared medication records against quantities of medicines available for administration we found numerical discrepancies and gaps in records of medicine administration, including records for the administration of anticoagulant medicine warfarin. We found medicines remaining in their containers where staff had signed to say they had administered these medicines This meant that people had not received their medicines as prescribed.

There were no records for the application of medicines prescribed for external administration such as barrier creams to protect people from acquiring pressure ulcers.

Where charts were in place to record the application and removal of prescribed transdermal pain relieving skin patches, there were gaps in the records. This meant that we were unable to determine if staff had administered patches in accordance with the prescriber's instructions to ensure people's safety and effectiveness of the medicine.

We noted that checks to balance medication stock and their records had not been conducted by the manager since June 2015. We were not assured that medication administration errors were identified and action taken to ensure that people received their medicines as prescribed.

Regulation 17.2 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, some people's health and wellbeing was at risk as their medicines were recently not administered because they had run out and were unavailable. This included a person's pain relief medicine, a person's medicine prescribed to manage and relieve the symptoms of Parkinson's disease and a medicine prescribed to manage diabetes. We also noted some medicines where the last dose had been administered during the time of inspection but which had not yet been re-ordered. Therefore these medicines may not have been available in time for the next doses scheduled for administration.

One person with a grade four pressure ulcer had been prescribed morphine, a pain relieving medicine to be administered prior to any wound dressing change. We found that although this medicine had been received into the service the day before our inspection, staff had failed to place the updated medication administration record in the administration folder and failed to communicate effectively to other staff. This omission impacted on this person, preventing them from receiving their pain relief medicines as prescribed. We were therefore not assured that sufficient pain relief had been administered as prescribed to protect this person from experiencing unnecessary pain.

We saw that staff followed safe procedures when giving people their medicines. However, the length of the morning medicine round was excessive so people did not always get their medicines at the times scheduled and intended by the prescribers. Staff told us that the morning medication administration round could last up to three and a quarter hours. People living at the service told us they did not always receive their medicines on time and that there were delays. One person told us their evening painkilling medicine was sometimes not received until the early hours of the morning leaving them in pain. This meant that procedures were not followed to enable people to receive their pain relieving medicine as prescribed.

Supporting information was not always available alongside medication administration record charts to assist staff when administering medicines to individual people. For some people there was no personal identification to help ensure medicines were administered to the right people. Given the service only employed agency nurses, some who would not be familiar with identifying people this was a serious concern as there was a higher risk for errors in agency staff administering medicines to a person they were not prescribed for.

Checks on blood glucose levels for people diagnosed with diabetes had not been carried out at the regularity as described in their care plans. This meant that steps had not been taken to identify risks to people's health.

Where people were prescribed medicines on a when required basis (PRN), there was no PRN protocol in place with guidance available to show staff how and when to administer these medicines. Therefore people may not have had these medicines administered consistently and as prescribed.

Inadequate

Is the service safe?

Medicines were stored safely for the protection of people who used the service and at correct temperatures. However, we noted that treatment room storage arrangements for medicines were chaotic and in a state of disrepair, untidy and unclean. Medicines stored in medicine trolleys were chaotically arranged and we noted staff experiencing difficulties finding some medicines. We found some containers of eye drops that had expired but were still in use.

Care staff authorised to handle and administer people's medicines had received training and had been assessed as competent to undertake these tasks. However, at the time of inspection there were only two members of care staff administering people's medicines that had received recent training. Training for a third member of care staff had not yet been completed. A member of care staff told us that in their absence registered nurses would need to administer all medicines.

This demonstrated a breach of Regulation 12.2 (b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we received information of concern from health care professionals that the service was providing woefully inadequate care and support to people at risk of and with pressure ulcers. One person identified with a grade four pressure sore was found by community nurses lying on a deflated pressure mattress. They also told us that when they raised concerns with the staff both verbally and in writing about faulty and inappropriate settings on pressure relieving air mattresses, these were not always communicated to other staff and action was not taken to safeguard people from the risk of harm. In response to these concerns a safeguarding alert was raised with the local safeguarding authority.

Risks associated with the use of pressure relieving equipment and the use of bedrails had not always been assessed and guidance was not provided for staff in the correct use of equipment. There was no system in place for the safety monitoring of pressure relieving equipment. Air mattresses were found to be set at incorrect air pressure settings for several people. For example, one person with a weight of 34.6kg had the air mattress pressure set for a person of 90kg. Another person weighing 45.1kg had the air mattress pressure set for a person weighing 80kg. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The impact for people where pressure mattresses were set incorrectly placed them at risk of further pressure damage. We asked the manager what systems they had in place for the regular and audit of pressure relieving equipment. They told us there was no regular audit in place to mitigate the risks to people. They also told us that there was currently no delegated clinical lead appointed for this task. We noted from a review of records that the last 'pressure area/wound audit' had been carried out by the manager in September 2015.

Prior to our inspection we received information of concern regarding the care and support provided to people with indwelling catheters. We asked nursing staff who was responsible for the catheter leg bag changes, they told us this was a sterile procedure and should be carried out by a nurse. We asked to see the records of these changes. Nursing staff told us there was no daily monitoring chart to show this was completed for people with in-dwelling catheters. One nurse told us this would be recorded on medication administration (MAR) charts. We found there was no record on MAR charts. Three agency nursing staff who told us they regularly worked at the service were asked if they had renewed any of the leg bags for anyone living at the service with in-dwelling catheters. All three nurses told us they had not. When asked if they knew when the last time any of the leg bags had been changed, they told us they did not know. This put people with an indwelling catheter at high risk of infection, as the bags deteriorate over time and could allow urine to backflow up the catheter into the bladder resulting in discomfort and infection.

There were ineffective systems in place to ensure people ate and drank enough for their needs. There were no detailed risk assessments in place with regards to meeting people's nutrition and hydration needs to show how risks were to be minimised. Where malnutrition records had been completed to assess those at risk there were no action plans in place with guidance for staff with actions to mitigate risks for people. For example, we identified three people who had been consistently losing weight over a period of four months. Where staff had sought guidance from a dietician for specialist advice, recommendations were not always recorded within people's care plans and specialist advice followed through.

Inadequate

Is the service safe?

This demonstrated a breach of Regulation 12(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, "There are enough staff during the day but never enough at night; I can't wait for it to be morning", "I can't move myself and there are not enough staff to help me, I don't like to ask and be a nuisance", "Yes there are enough staff during the day but not enough at night", "Lots of staff have left, there were some lovely caring girls but they are all gone now" and "I am supposed to have my pain killers and sleeping tablet at 9:30pm, sometimes I am woken up after falling asleep in my chair at 12 midnight or 2am by staff as I have fallen asleep waiting for them." One relative told us, "[relative's] mobility has deteriorated rapidly since they came into this home. I have asked the staff if they would support [relative] to walk down the corridor to keep them mobilising. Staff tell me they just don't have the time." Another relative told us, "[relative] just lies in bed all day. They came in here walking and now look. I just don't understand why they can't sit them up in a chair instead of just lying there all day looking into space. What kind of a life is that?"

Staff told us, "There is not always enough staff but we work as a team to get the jobs done", "Some days there are staff who just don't turn up and that is hard. You just do the best you can", "We need our own nurses and then things will improve. There are some agency nurses who come here regularly but things just don't get done like they should do" and "We never have enough nurses."

We saw that staff were busy throughout the day and that care was not delivered in a timely manner and not always according to individual's preference. We observed call bells not responded to for up to seven minutes on several occasions. We noted that the majority of people stayed in bed throughout the day. All of the relative's we spoke with told us there was not enough staff available whenever they visited the service. One relative told us, "There is never enough staff. My [relative's] mobility has deteriorated since they came here and it has happened very quickly. I have asked staff to at least help [relative] to walk a little each day along the corridor but they tell me they don't always have the time. It also took three months before [relative] got any help with a shower and only because I complained. What happens to people who have no one to complain on their behalf? Another relative told us, "I do not understand why [relative] cannot be helped to sit in a chair during the day, I ask but they are just left to lie in their bed all day. [Relative] always looks so unkempt. I have to chase to get staff to remind staff to give them a bath and hair wash. This is no way to be treated. [relative] was always proud of their appearance." We asked the manager why there were so many people left in bed. They told us this was due to people's choice to do so. We noted that people's choice in relation to how they spent their day was not recorded within the care plans we reviewed.

Prior to our inspection we received information of concern from a variety of sources that staffing levels were insufficient to meet the needs of people. The homes manager told us they regularly worked shifts to cover shortages on the rota. There was no member of staff currently delegated to carry out the role as clinical lead at the service. There were also no qualified nurses employed directly by the provider. The manager told us and this was confirmed from rotas that all nursing staff were employed directly from nursing agencies. The manager told us they had experienced difficulties in trying to recruit permanent nurses. This meant that there were no clinical staff with direct responsibility for delegated tasks such as the management of medicines, monitoring of people's nutrition and hydration needs, catheter care and wound management. There was no one within the service with responsibility for clinical supervision or designated to carry out checks on the clinical competencies of nursing staff. It was evident from information received prior to out inspection and our discussions with nursing staff that some did not have the clinical skills needed to meet the needs of people safely and effectively. For example, not all nursing staff had updated skills and knowledge in catheter care and wound management. We were therefore not assured that there were sufficient numbers of skilled staff, available to provide the care and support that people needed.

Staff, relatives and health care professionals told us that the absence of a clinical lead and the lack of consistent registered nurses employed within the home had resulted in a lack of continuity of care for people and communication breakdown. They told us that verbal and written messages about the care of people had not been passed on or actioned. When community nursing staff instigated a new treatment or requested different tests they backed this up in writing to be placed in the people's care records. However, they also told us they repeatedly had to chase up because requests had not been actioned for

example; blood tests and urine tests. We were therefore not assured that the provider had taken action to do all that is reasonably practicable to mitigate risks and protect people's health, welfare and safety.

This demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we received information from a variety of sources including health professionals who told us that the premises and equipment were not kept clean and free from odours. Concerns included inadequate access to soap and paper towels and safe, easy access to personal protective equipment such as disposable gloves and aprons. We found during our inspection that there was availability for staff to personal protective equipment. However we found some rooms without soap and paper towels. There was a lack of audits and systems in place to maintain safe and appropriate standards of hygiene. Although domestic staff had signed to say they cleaned designated rooms we found standards of cleanliness to be poor throughout. We found dirty bedding and stained mattresses. There was a strong odour throughout the service, in some areas worse than others. The treatment room was found to be dusty, dirty with dead flies found on the floor and window sill where clean sample bottles for blood and urine samples were stored. Carpets and soft furniture were found to be soiled and stained throughout.

Suction machines used to remove secretions of food; mucus and fluid from people vulnerable to choking were found without suction catheters. When asked two agency nurses told us they were unable to find any. They also told us they had never seen any and did not know where to find them or how to order new stock. The lack of available suction catheters alongside staff lack of skills and knowledge put people at increased choking risk as suction catheters should be available at all times, especially for frail people with swallowing difficulties and those at the end of life as swallowing issues are often present.

Syringe driver equipment was found to be stored within a plastic carrying box which was dusty and dirty. The clear plastic covers on the syringe drivers were also dirty and had not been wiped. One cannula in the box was found to be out of date and we requested that this be disposed of immediately. An agency nurse when asked what records were available of checks and cleaning schedules for this equipment told us they thought night staff did this but were not aware of any records to evidence this.

This demonstrated a breach of Regulation 15 (1)(a)(c)(d)(e) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, "I do feel safe but sometimes I have to wait a long time for someone to come when I press the bell" and "I feel safe as I have a buzzer to press and have daughters who visit me, there is always someone visiting to sort things out for me."

Staff told us they received training in safeguarding people from the risk of abuse. Staff demonstrated their understanding of what constituted abuse and what they would do if they suspected abuse of any kind and how they would raise alerts if they had concerns. Staff knew about whistleblowing and who to contact if they had concerns. However, despite this response from staff there was little evidence that systemic concerns had been raised by staff with the manager at the service.

Inadequate

Is the service effective?

Our findings

People told us, “Most staff seen to know what they are doing”, “The new ones take time to pick things up and you have to tell them what you need” and “They do their best and I don’t complain what good would it do?”

Staff told us they had received training opportunities within the last 12 months to refresh and update their skills and knowledge. One staff member told us, “I had a really good induction, better than where I worked before.” Another told us, “We are always updating our training, I have nearly finished by NVQ3 and then the manager is going to put me forward for a leadership course.” Staff told us that they had regular opportunities for supervision but staff meetings were sporadic.

There were no directly employed nursing staff. All nursing staff were employed directly through nursing agencies. There was insufficient monitoring carried out by the provider to evidence that agency nursing staff had the required skills and knowledge to meet people’s health, welfare and safety needs.

Prior to our inspection we received information of concern from health care professionals who told us that on occasions they found agency nursing staff who did not have the required skills and knowledge to meet the needs of people with indwelling catheters. For example, community nursing staff were told on occasions that there was nobody on duty to deal with a blocked catheter, a fundamental nursing skill. There was no clinical lead in place to with delegated responsibility to provide clinical supervision and oversight for nursing staff and assessment of nursing staff competencies.

This demonstrated a breach of Regulation 18 (1) (2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments and care plans were not reviewed regularly to reflect people’s current care needs and lacked sufficient information and guidance to guide staff in mitigating risks to people’s health, welfare and safety. For example, the care records in relation to the management of people’s pressure ulcers were inaccurate and poorly documented. There was a lack of updated wound care plans and evidence of regular monitoring of people’s skin integrity. This meant there was a lack of recorded guidance within care plans for staff to take action to prevent pressure ulcers. For those people identified as at risk there was insufficient monitoring for improvement or identifying deterioration.

One person had a notice on their bedroom wall informing staff that this person was on restricted fluids of 1000 mls in 24 hours for medical reasons. This conflicted with information found in their care plan which recorded there were no restrictions on their fluid intake. Although staff had recorded some fluid intake staff did not monitor the total fluid intake within a 24 hour period for all of the people we reviewed.

Food and fluid charts did not always identify the amounts of food and fluid consumed and some of the records we reviewed were illegible to read. Staff had failed to carry out any analysis of people at risk of malnutrition and dehydration to ensure they were eating and drinking sufficient amounts to meet their needs as all of the forms we reviewed which guided staff total up at the end of the day had been left blank. Staff had also not recorded if any refusal had been followed up. We asked the manager and staff whose responsibility it was to carry out any audit and follow up any discrepancies or non-analysis of food and fluid charts. We received differing opinions as staff were unclear as to whose responsibility it was. We identified two people whose records indicated a fluid intake of less than 250 mls in 24 hours on three consecutive days. The amount recommended by nutritional guidance for the weight of the person stated 1100 mls in 24 hours. Action had not been taken to protect people from the risks of inadequate intake of nutrition and we found a lack of action to ensure people were sufficiently hydrated.

People had mixed views regarding the quality of the food provided. One person told us, “All I have is mashed potato or eggs, and I get sick of it.” We noted that this person required a soft diet but said they had not been given a choice of foods. Another person told us, “I don’t like the food and I have told them. I like chicken and all you get is chicken drumsticks. By the time you have taken the skin off there is hardly any meat left.” Other comments included, “The food is normally ok, we have fresh fruit”, “The food is lovely you can’t fault it” and “You have enough to eat.”

We observed one person struggling whilst trying to remove the skin from their potatoes. They told us they did not like

Is the service effective?

skin on their potatoes but that no one ever listened when they had told them this. We also observed that at no point did staff approach this person to offer support and neither offer an alternative.

People who ate in their rooms were checked by staff intermittently to ensure they were eating, but this was not consistent throughout. We observed people sitting with food uncovered, waiting for staff to assist or prompt them to eat. This meant their food was potentially left cold to eat.

Staff assisted people in bed to eat by standing and reaching over bed rails. For some there was little interaction observed and it was not an enjoyable experience for people.

This demonstrated a breach of Regulation 14(1) (2) (3) (4)(a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to health care professionals such as GP's and community nurses but referrals were not always made promptly and their advice was not always followed consistently. Prior to our inspection health care professional told us that action in response to people's health care needs and communication in the service was woefully inadequate. For example, urine and blood samples requested both verbally and in writing had not been actioned for people until several weeks later. This had impacted on people gaining timely access to health screening and put their health and welfare needs at risk of not being met.

This demonstrated a breach of Regulation 12 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

We received mixed feedback from people who used the service and their relatives. People told us staff were in the main kind, caring and compassionate but also told us they were busy and had little time to interact with them and support them in a manner which respected their individual choices and preferences. On person told us, "I'm well looked after." Another told us, "I am not happy here. I do not like it and I wish I could leave."

We observed a high number of people in bed during the day and a lack of staff going into their room to chat and only when needing to deal with personal care tasks. Staff were observed knocking on doors but did not always wait to be asked before entering. The majority of interactions observed were task focussed such as assisting people to mobilise or when serving meals.

People were not consistently treated with dignity and respect and they were not encouraged to be independent or to live a life of their choice. One relative told us they had recently found their relative distressed citing an incident where they had requested staff support to access the toilet. Staff had told them to go in their continence pad instead. This action did not promote this person's dignity and respect their choice. We looked at this person's care plan and found that their choices, wishes and preferences with regards to their continence needs had not been assessed appropriately and their choices recorded and respected.

We observed the lunch time meal in the ding room. The meal service was not a positive shared experience or made to feel like an enjoyable event for people. It was observed to be rushed and had become a task rather than something to be looked forward to. Whilst there were dining tables available on the first floor for people to eat at, the majority of people ate in their room. Whilst we saw some staff attentive to people and chatting whilst they supported people with eating their meal, we saw one staff member stood over a person, not sat at eye level and barely spoke to the person throughout the meal. Whilst the food was hot this member of staff was observed blowing on the person's fork of food each time before they ate. This presented as a risk of cross contamination for the person.

The provider's log of complaints evidenced a complaint where a relative had raised concerns that their relative had been supported with a shower whilst the door remained opened on to a corridor where people walked past and could see directly into the room. Staff had told the relative the door remained open due to the light not working within the shower room. This action meant that this person's right to privacy and dignity had not been respected and promoted. We found during this inspection that the shower room was still without a working light. This showed us that people's dignity and privacy was still potentially being compromised and the service was not actively listening to people and their feedback.

This demonstrated a breach of Regulation 10 (1) (2)(a)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People told us they did not always experience responsive care which met their needs. Comments included, " I don't have a bath or shower as often as I want", "The staff are kind and helpful", "I have to ask staff to cut my nails sometimes they are always too busy", "I like the staff but my favourite one has left and I miss her, she used to stop and chat with me. No one does that anymore. They have a job to do and I must let them get on."

Whilst some people told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to individual needs. All of the people we spoke with told us they had not been involved in the planning and review of their care. No one we spoke with was aware of any care plan specific to them.

The daily observation and monitoring folders which contained daily observation notes were left on the floor just inside each person's room. This presented a risk to people and staff with regards to infection control and also did not protect the confidentiality of people's information.

Risk assessments and care plans were not reviewed regularly to reflect people's current care needs and lacked sufficient information and guidance to guide staff in mitigating risks to people's health, welfare and safety. For example, the care records in relation to the management of people's pressure ulcers were inaccurate and poorly documented. There was a lack of wound care plans and evidence of regular monitoring of people's skin integrity. This meant there was a lack of recorded guidance within care plans for staff to take action to prevent pressure ulcers for those people at risk and monitor improvement or deterioration of people at risk and those with identified pressure ulcers.

People's continence needs were not effectively assessed and managed which incorporated people's choices and preferences. There were no systems in place to evidence when people who had a catheter in situ had their catheter bag changed. There was no guidance within people's care plans for promoting a person's choice with regards to their continence such as supporting them to access the toilet or promoting to use the bathroom.

There was insufficient care planning for people living with dementia. Care plans did not identify what type of dementia people had been diagnosed with, how people's dementia presented and did not provide the guidance for staff in meeting people's needs when they presented with distressed reactions to situations or others.

Care plans reflected some people's specific need for social interaction, but these were not being met. There were times when we saw that people were isolated and staff interaction was minimal due to other tasks being undertaken. The activity person was enthusiastic about their role, but told us that it was difficult to ensure everyone received an opportunity for activities due to the high percentage of people who remained in their room.

Staff said people preferred to stay in their room and so no longer offered to take them to the communal lounge.

Records showed us that the activity co-ordinator spent time on one-to-ones sometimes but this was not regular. This also meant if the activity co-ordinator was visiting people in their room, the people in the communal areas were left watching television. Activities promoted were not reflective of people's individual interests and hobbies. One person told us that trips out would be good, especially Christmas shopping. It was not clear from talking to staff if outings were offered or planned on a regular basis.

People told us there were activities which took place in the morning and afternoon Monday to Friday. Activities included dominoes, scrabble, card games and bingo. There was a Christmas party scheduled and a carol service for the following week. One person told us, "I like reading the newspaper and I have one delivered every day." We observed a significant number of people who were isolated in their bedrooms with little interaction from staff. We asked staff how these people were supported to access social and leisure opportunities. They told us that the activities coordinator would visit people to paint their nails if they wished.

Prior to our inspection and also during our inspection people and their relatives expressed concern regarding the lack of support to access regular opportunities for baths and showers. Several people looked unkempt whilst others had their hair done from services provided by the visiting hairdresser.

There were people observed whose only opportunity of respite from lying in their bed was meal times when they were sat up and assisted with their meal. The manager told

Inadequate

Is the service responsive?

us that people chose to stay in bed. However, relatives told us that this was not always people's choice and that despite repeated requests to staff their relative's stayed in bed.

Care plans did not evidence that people had their individual needs, wishes and preferences adequately assessed and regularly reviewed in relation to their interests and hobbies and how these could be supported and provided for.

This demonstrates that delivery of care was seen as task based rather than responsive to individual needs. This meant that people were at risk of not receiving person centred care that reflected their individual needs and preferences.

This demonstrated a breach of Regulation 9 (1)(2)(3)(b)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were provided with when requested only one copy of a residents meeting. This demonstrated that people had been asked for their views about the quality of the food provided and activities. However, where people had expressed dissatisfaction with the food provided there were no action plans in place to evidence any action had been taken in response to people's comments.

Inadequate

Is the service well-led?

Our findings

We found the service was not well-led. We found that there was a lack of clinical governance. The registered manager was not a trained nurse and the post of deputy manager where previously this person would have been the clinical lead had been vacant for several months. There were no clinical audits in place which would have identified the shortfalls we found at this inspection. We were therefore not assured that action was taken to identify and mitigate the risks to people's health, welfare and safety.

There were no effective systems in place to monitor effectively and proactively the quality and safety of the service provided. The provider failed to operate effective systems and processes to make sure they assessed and monitored the quality and safety of the service on a regular basis. The environment and equipment for people was not suitable to support people safely and ensure people's individual needs were met.

A 'mock inspection' audit was carried out by an external provided in May 2015. Feedback from this audit identified shortfalls in the overall day to day management of the service in relation to a lack of regular provider and manager auditing of the quality and safety of the service. Recommendations were made by the external auditor to improve in this area. However, this had not been actioned.

Where some audits that had been carried out by the manager, these were found to be sporadic, not fully completed and had not identified the shortfalls we found. The area manager told us they spent a considerable amount of time at the service supporting the manager. However, they also told us there was no recent documentary evidence of any checks carried out on the quality and safety of the service and they were unable to account for the reasons why this was the case. This meant there was a failure to identify where the quality and or safety of the service was being compromised. There was a lack of learning from incidents concerns and complaints in planning for the continuous improvement of the service and planning for action to respond appropriately and without delay to mitigate the risks to people's health, welfare and safety.

There was a lack of care plan audits which would have identified that people's specific health needs had been reviewed and did not accurately reflect their current care needs. We found a lack of action taken to protect and meet the needs of people identified as at risk of malnutrition, dehydration, and care for people with in-dwelling catheters and pressure ulcers. People were not protected from the risks associated with improper operation of the premises. This meant that the safety and welfare of people using the service was at risk and the provider was failing to provide a safe, effective and responsive service.

This demonstrated a breach of Regulation 17 (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the manager was, "supportive" and "Will always help when asked." Other comments included, "The manager is approachable and always has her door open. Nothing is too much trouble." And "You only have to ask and they will try to sort it." However, staff, relative's and health care professionals also told us, "The communication is poor", "The manager tells you they will get back to you but never does" and "Communication and action where needed is not forthcoming and lacking."

Relative's and people who used the service told us the culture of the service had changed and deteriorated in recent months. They told us there had been a lack of good, visible leadership since the departure of the deputy manager and the high number of agency staff being used as a result of a lack of nursing staff directly employed by the service.

The manager told us that staff meetings took place regularly. When asked we were only provided with one copy of staff meeting minutes. One recently employed member of staff for four months told us they had not attended any staff meetings and had not been given access to minutes of any meetings.

The provider had not notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. This meant that people who used the service could not be assured that the provider took steps to report important events that affect their health, welfare and safety so that, where needed, investigations could take place and action taken. Despite repeated requests the manager failed to provide us with sufficient evidence that they had notified us of people with Grade three and above pressure ulcers.

This demonstrated a breach of Regulation 18(2)(a)(iii)(b)(ii) (Registration) Regulations 2009

Inadequate

Is the service well-led?

The provider did not have a robust system in place to evidence their response and outcomes following investigations into people's concerns and complaints about the quality of the service provided. Relatives and healthcare professionals told us that when they were concerned about the health and welfare needs of people and the manager was often unavailable and too busy to speak with. People told us of several occasions when they were told the manager was too busy and promised phone calls did not happen in response to their concerns. One relative told us, "I have complained about the food, my [relative] not having their pain killers on time and their not having a shower. I don't know what has been done about it because no one has told me. I have complained but they don't listen, nothing gets done." Another relative told us, "I am always having to chase to get things done and when I complain I do not always get a response." Health professionals told us they had sent letters complaining about the standard of care in response to people's health care needs and did not always receive a prompt response. This they told us put people at risk of not having their health care needs met in a timely manner.

We asked to view the provider's complaints records. We saw that there were eight formal complaints documented as received within the last 12 months. Complaints received related to mismanagement of people's medicines, a lack of support with showers and baths and inadequate support with meeting people's nutrition needs. The provider's system for logging complaints did not evidence investigation and outcomes for two of the eight complaints received. We discussed this with the manager and area manager. We were not provided with a reason for this.

We noted that the last complaints audit carried out by the provider was last undertaken in December 2013. We were therefore unable to identify what management action had been taken in response to people's concerns and what if any action had been taken in monitoring concerns and complaints and plans for driving forward continuous improvement of the service.

This demonstrated a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Safe care and treatment** Regulation 12 (2)(a) The provider did not take steps to respond to people's needs for health screening and take appropriate action when there was a need to provide urine and blood samples for assessment in a timely manner to mitigate the risks to people's health and wellbeing. Regulation 12.2 (b) The service did not protect people against the risks by way of doing all that is practicable to mitigate any such risks. Regulation 12.2 (f) The service did not ensure that there were sufficient quantities of medicines to ensure the safety of service users and meet their needs.

The enforcement action we took:
Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Good governance**

This section is primarily information for the provider

Enforcement actions

The provider failed to sufficiently and regularly assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity.

The provider did not have established systems in place to assess, monitor, mitigate risks for people who used the service and improve the quality and safety of the services provided from the regulated activity.

The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:
Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14(1) (2) (3) (4)(a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Meeting nutritional and hydration needs** The provider failed to assess, monitor and protect people from the risks of inadequate nutrition and dehydration.

The enforcement action we took:
Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 (1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Staffing** There was insufficient numbers of suitably qualified, competent, skilled and experienced staff available at all times to meet people's needs and mitigate the risks to their health, welfare and safety.

The enforcement action we took:
Notice of decision to restrict admissions.

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (1) (2)(a)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Dignity and respect** Service users were not always treated with dignity and respect.

The enforcement action we took:
Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 (1)(a)(c)(d)(e) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Premises and equipment**

This section is primarily information for the provider

Enforcement actions

Premises and equipment were not kept clean in line with current legislation and guidance, suitable for the purpose for which they were being used; and failed to take steps to ensure the premises were properly maintained.

The provider failed to maintain standards of hygiene appropriate for the purposes for which they were being used.

The enforcement action we took:
Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 (1)(2)(3)(b)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Person-centred care

People did not have their individual needs, wishes and preferences adequately assessed and regularly reviewed in relation to their plan of care including their interests and hobbies and how these could be supported and provided for.

The enforcement action we took:
Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **This demonstrated a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Enforcement actions

Receiving and action on complaints.

The provider did not operate and effective system for identifying, receiving, recording handling and responding to complaints.

The enforcement action we took:
Notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18(2)(a)(iii) (b)(ii) (Registration) Regulations 2009** **Notification of other incidents** The provider failed to take steps to report important events that affect people's health, welfare and safety so that, where needed, investigations could take place and action taken. Despite repeated requests the manager failed to provide us with sufficient evidence that they had notified us of people with Grade three and above pressure ulcers as required.

The enforcement action we took:
Notice of decision to restrict admissions.