Morecare Limited

# Old Vicarage Nursing Home

## Inspection report

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Tel: 015436838333

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09 October 2017

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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? | **Inadequate** |

# Summary of findings

## Overall summary

We inspected Old Vicarage Nursing Home on 9 October 2017 and it was unannounced. The home was previously inspected on 11 January 2017 and had been rated 'good' overall with improvements required to keep people safe from harm. This inspection was brought forward and prompted in part by the failings of the provider's other service. The concerns we had at that location resulted in us taking urgent action to close the service. We found that there were similar concerns at this location and that the provider had not put measures in place to protect people from the same failings. There was no learning evident from the provider's previous failings nor any new systems implemented to ensure that there was not a repetition of the concerns.

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

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

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

Old Vicarage Nursing Home provides nursing care and support for people, some of whom are living with dementia. It is registered to provide care for 30 people and at the time of our inspection 26 people were living at the home.

Risks to people's health and wellbeing were not adequately assessed and managed leaving people at risk of harm. Where risks had been identified the provider did not always take action to remove or minimise the risks. Changes to people's health were not always responded to by referring them to healthcare professionals. Some people did not receive enough support with eating and drinking. Staff did not always

have the skills to be able to support people effectively and the provider did not have a system in place to routinely assess their competence.

Medicines were not always managed or administered to people as prescribed. The recording was not always clear to ensure that staff knew how to administer them. The systems in place to monitor the risks associated with medicines were not effective in highlighting errors and concerns.

There was not a registered manager 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 the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. There was a manager but they were only available to support the home on a part time basis and did not have the systems in place to have a good oversight of concerns. Staff did not receive leadership and support to know their responsibilities well. They did not receive adequate training to be able to support people effectively. They were not always deployed well to ensure that they could meet people's needs in a timely manner.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. Some people were not enabled to make their own choices because their communication needs had not been met. When people did not have the capacity to make their own decisions best interest decisions were made on their behalf but they were not always followed.

People's dignity and privacy were not always upheld and they were not always spoken to kindly. Their preferences were not always planned for and when their needs changed their care was not always reviewed.

People were not always protected from harm and abuse because incidents were not fully investigated and staff did not always recognise potential safeguarding concerns.

People's care plans were not always altered to reflect a change in their support needs and so did not assist staff to provide a personalised service. Opportunities to pursue hobbies and interests were limited for some people.

Complaints were managed in line with the provider's procedure.

We found 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. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People were not always protected from harm because risk was not effectively assessed, mitigated and managed. They were not always protected from abuse because incidents were not always investigated or reported to ensure that people were kept safe. Medicines were not managed to reduce the risks associated with them and to ensure that people received them as prescribed. Staff were not always deployed effectively to be able to meet people's needs promptly. Safe recruitment procedures had been implemented.

### Is the service effective?

**Inadequate**

The service was not effective.

People were not always provided with the correct food and drink to ensure that they were kept well. Their healthcare needs were not always responded to or referrals made to other professionals. People did not always consent to their care and when decisions were made in their best interest these were not always followed. Staff did not always have the training and support to ensure that they supported people well.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were not always supported in a caring manner and were not always spoken to with respect. Their privacy and dignity were not always upheld. Families and friends were free to visit the home when they wanted to.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People's care was not always planned to meet people's needs or reviewed when their needs changed. Their plans were not always up to date or clear to give staff guidance. Some people were provided with activities that they enjoyed but others were

not engaged. There was a complaints procedure in place which the provider followed.

## Is the service well-led?

**Inadequate**

The service was not well led.

The systems in place to monitor the quality of the home were not effective. The provider did not demonstrate that they had learnt from previous incidents or recommendations. The manager was not always available to lead the service and information about people was not always effectively monitored and shared.

# Old Vicarage 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.

Two inspectors and a specialist nurse advisor completed this unannounced inspection on 9 October 2017. We had not requested that the provider should complete a provider information return (PIR) on this occasion. 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. We gave the provider time during the inspection to update us on any information they wished to share.

We used a range of different methods to help us understand people's experiences. People had varying levels of communication and most were unable to speak with us at length; so we observed the care and support staff provided in the communal areas of the home. We spoke with two relatives about their experience of the care that the people who lived at the home received.

We spoke with the nurse, the manager, the care co-ordinator and seven care staff. We reviewed care plans for eleven people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Inadequate

# Is the service safe?

## Our findings

At our last inspection we found that the provider needed to make improvements in medicines management and moving people to ensure that people were kept safe. At this inspection we found that these improvements had not been made and that further improvements were required.

People were not always supported to move safely. We saw that one person was supported to walk by staff holding them under their arms. They were walking on their toes without shoes on and looked unsteady. When we reviewed their records we saw that it said that they could weight bear but not mobilise. Therefore, they were not supported in line with their assessment and this could have caused them harm. We saw that other people were assisted to move from their chair by two staff who lifted them from under their arms. We also observed other occasions when people were assisted to walk by staff who had their hands under their arms. This does not follow national guidelines on the safe handling of people and could cause pain and injury to the person and the staff.

People were not always assisted to move safely using hoists. We saw that one person was moved in a sling that may not have been the correct size for them. The sling did not fully support them. There was no risk assessment in place for them to be moved in this way. Therefore, we could not be assured that they were safe to be moved using this equipment. This meant that they were at risk of falling or injury. We saw a second person was moved using a hoist and that they were not in the correct position during the manoeuvre because they were leaning back. This meant that they were at risk of falling from the sling. We reviewed records and spoke with staff and found that individual slings had been ordered for some people without them having a professional risk assessment completed. One member of staff told us that they had decided which slings would be best for people based on their sizes. The only equipment available to staff to move people was a manual hoist and we saw that three staff were needed to because one needed to use the lever to work the hoist. When we spoke with care staff they said, "We don't have any equipment apart from the hoists. One person has a frame but they're not safe to use it". This demonstrated that risk to people had not always been assessed and that the provider had not ensured that people had the equipment they required to be able to be moved safely.

Some people were assessed as being at a higher risk of choking and had guidance in place about the specialist diets that they should have to reduce this risk. We saw that people did not always receive the correct meals in line with this guidance. For example, one person was assessed as requiring a fork mashable soft diet and liquids which were thickened. Some of their meal was not mashed and their drinks were not thickened. When we spoke with staff they were not aware that it should be thickened and confirmed that they always had their drink without thickener. Another person was assessed as requiring puree meals but ate food which had not been. This meant that staff did not follow the guidance to ensure that the risks to people's wellbeing were reduced.

When people's fluid intake was important to their health it was not always monitored to ensure that it was sufficient. For example, one person had a condition which meant that that their fluid should be regularly monitored and amended if there were signs of ill health. We saw that this was not regularly completed and

there was not a plan in place for staff to follow so that they could understand this risk.

People were not always supported in line with their plans when they were at risk of developing sore skin because of pressure; and some people did not have plans in place. One person was assessed as being at high risk of pressure wounds and should be moved hourly. We saw and staff confirmed that they moved the person every three hours. Another person had sore skin and there was a plan in place to say how often they should be moved in order to relieve pressure. We looked at records and saw that they were not moved as regularly as they should be. It was also not clearly recorded which side they had last been leaning on so that staff could be assured that they were moved correctly. When we spoke with the manager about this they said, "I see what you mean by that; they are not being specific about turns". A third person was assessed as being at very high risk of pressure damage did not have a plan in place to monitor their skin. This meant that the provider had not ensured that people always had the plans and support in place to reduce the risk of damage to their skin.

Medicines were not always effectively managed to reduce the risks associated with them and to ensure that people received them as prescribed. We saw that the information recorded on the medicines administration records (MAR) was not always clear. For example, for one person it was not clear whether they should have their medicine for diabetes before or after a meal, dependent on their blood sugar levels. We saw that the person was administered this medicine after lunch but when we checked, their blood measurement had not indicated that this was needed because it was within a normal range. When we spoke with the member of staff they told us that they had not been sure and had made the decision on what was recorded on the MAR which they recognised was not clear.

Some people did not receive their medicines as prescribed. For example, one person was prescribed a medicine to help them to be calm which they should take once in the morning and then in the afternoon if needed. We saw that they were administered this two times every day with no record of why it was needed on the second dose. Another person was prescribed a medicine to be taken twice a day but they had only been given one dose in the past two weeks. A third person was prescribed a medicine to be taken three times daily and they were not always given it but staff recorded that it was not required on the MAR. It was prescribed medicines and was not to be administered as required, or PRN. Other people were prescribed PRN medicines to support their health. The frequency of the administration of this medicine needed to be reviewed in line with other daily records of their health. This was not completed to ensure that the medicines were administered appropriately. There was no written guidance in place to advise staff how PRN medicines should be given, the maximum dose or when medical assistance should be sought. This demonstrated to us that staff were not always clear about how and when to administer some medicines.

Other people did not receive their medicines on the day that they were supposed to have it. Two people were prescribed medicine which needed to be taken weekly on a set day. We saw that for two weeks none of these were administered on the correct day. This could impact on the effectiveness of the medicine and could cause harm to the person because the correct gap wasn't maintained between administrations.

Six people were given their medicines covertly, which means without their knowledge. Medicines can be given covertly if the person does not understand that they are essential to maintain their health and wellbeing. We saw that their capacity to make this decision had been assessed and that the decision to administer their medicines in this way was made in their best interest with guidance from relevant healthcare professionals. However, there was no plan in place to describe in what circumstances medicine should be given covertly, how to administer it and when this should be reviewed. In addition, we saw that when one person declined to take their medicine that a staff member put it into their food. There was no assessment for this person and staff had not checked with healthcare professionals to ensure that the

medicine could be given in food safely. This meant that the provider had not followed all of the guidance to ensure that medicines were only given covertly in exceptional circumstances.

Some people were prescribed thickener for their drinks to reduce the risk of choking. We saw that one tub of thickener was used for four separate people. This is not in line with best practise guidance and each person should have had an individual prescription for this.

The environment was not always managed to reduce risks to people. We saw that the stairs were cluttered and had prizes for an event on them. It is important that stairs are kept clear so that people and staff have access if there was an emergency requiring evacuation. There was planned work happening because fire door were being fitted. This information had not been shared with all staff to ensure that they could adapt their support for people. There was not a risk assessment completed to manage the work and reduce the risk to people and we saw that it took place in communal areas where people were sitting. We saw that there was dust and that some people were disturbed by the noise of the machinery used.

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

People were not always protected from harm and potential abuse. We observed that the way some people were supported to manage the risks to their wellbeing was not proportionate and that it restricted their freedom. For example, it was considered that one person would be safer to sit in a chair because the way they chose to move posed risks to others. We saw that each time they tried to stand they were told to sit down. On one occasion when they stood, the member of staff put their hands on the person's shoulders to guide them back into the chair. This was a restraint which had not been assessed or agreed and it was not in the person's care plan. Another person spent the day in their bedroom. When we asked why they were there, a member of staff told us that they were better there because they could get agitated and 'annoy' others in the communal areas. This had not been risk assessed and there was no plan in place to support this.

We saw that incidents and accidents had occurred which were not investigated or reported to safeguarding to ensure that people were not at continued risk of harm. One incident described how someone was injured when they were agitated whilst receiving personal support. There was no review of the support they received and the incident was not reported to the safeguarding authority. We saw that one person had a bruise to their arm which had not been recorded or reported. When we spoke with staff they were unable to tell us how it may have occurred. One other person had a bruise to their face which we saw was recorded as happening 17days earlier. It was recorded that they had fallen onto a soft surface. There had been no further investigation into the incident when the bruising was still evident at such a time lapse.

When we spoke with staff they had a varying degree of understanding about their responsibilities to report any concerns which they thought could be considered abuse. For example, one member of staff was unsure how people who lacked capacity could report their concerns and whether they would be reliable. Other staff could tell us what the signs of abuse could be but had not necessarily recognised the incidents we identified as potentially harmful to people.

This evidence represents a breach of Regulation 13 of the Health and Social Care Act 2008. (Regulated Activities)

Staff were not always deployed to ensure that people's needs were met effectively. We saw that when people were moved by hoist that three staff or sometimes four assisted in this manoeuvre. This meant that

people were moved to the dining room for their meal slowly and it took a prolonged time. Some people had been in the dining room for one hour before they ate; and for some people the meal time experience took nearly two hours. When we arrived for the inspection visit we saw that all of the people who lived in the home were in seats in the lounge. All of the staff were engaged in completing paperwork in the same room and none of them were interacting with people. One member of staff told us that people had been moved to the communal area early because they were expecting workmen to replace fire doors that day. Staff were not deployed to support people to spend time out of the room where the work was taking place and we saw that it took place around people.

The provider had received an action plan from the local authority before our inspection which gave them recommendations to ensure that when they recruited staff that they ensured that they were safe to work with people. We saw that they had followed these recommendations and completed additional checks. For example, when we looked at staff files we saw they had now ensured that they had two references in place for each member of staff.

Inadequate

# Is the service effective?

## Our findings

People were not always supported to have enough to eat and drink to meet their needs. We saw that one person sat at a table with others and ate some of the other person's meal and drinks. We had to intervene to ensure that the people had new drinks after theirs had been drunk because staff had not observed the situation. When we spoke with staff about this they were aware that the person may do this but they had not ensured that they were supported or sat away from other people's food. The person needed a puree meal and thickened drinks although we saw they took others food and drank an unthickened drink. This demonstrated to us that people had not had enough support to ensure that they could eat and drink safely.

Some people had their meals in a puree form because of their assessed risk of choking. We saw that the food supplied was very liquid and that different parts leaked into each other until people were presented with one mixed liquid form. When we looked at records we saw that one person's assessment stated that they should have 'normal food cut into smaller bits'. When we asked why they were having a puree meal we were told it was because staff were concerned that they had recently lost weight. Staff had made the decision to give them food in this form, although they were not at risk of choking. One member of staff said, "It was my decision because I thought it would be easier for them to eat like this". We discussed this with the manager who recognised that providing the person food in other ways may have been a more effective way to address their weight loss.

People did not have a choice of meal to ensure that their appetite was sustained by eating their preferred foods. We saw that staff chose people's meals for them. We heard them ordering meals like 'a soft' from the kitchen and then presented them to people. They did not tell people what they were going to eat and food was already plated up so people did not have a choice of what to eat. This meant that the mealtime experience was not always their preferred choice.

People's cultural backgrounds were not taken into account when planning their meals. We saw that people who had a different cultural background did not have meals from this culture. People had not been consulted about any dietary preference they may have. One member of staff we spoke with said, "We have done training in human rights and know it covers people's culture but we hadn't really thought about it in terms of meals for that person".

People were offered fruit as a snack during the day. However, we saw that some of this was not cut small and so not everyone was able to eat this. For example, one person was offered a piece of melon which they were unable to eat and we had to intervene and ask for them to be assisted to dispose of it because they were coughing and showing signs of choking as they tried to eat it.

When we looked at MAR we saw that some medicines were out of stock and some of these were high calorie diet supplements. This meant that when weight loss was recognised and additional nutritional support was prescribed, it was not always available to give to people to ensure they had enough nutrients to maintain their health and wellbeing.

This evidence represents a breach of Regulation 14 of the Health and Social Care Act 2008. (Regulated Activities)

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA. We saw that people did not always consent to their care and support. For example, we saw that people were moved in their wheelchairs without telling them what was going to happen or asking their permission. We saw one person's foot lifted and put on a footplate of a wheelchair without asking them. When staff tried to support someone to be hoisted we saw that the person communicated that they did not want it by gesture. The staff did not respond to this and continued with moving the person.

When people were not able to make some decisions for themselves we saw that capacity assessments and best interest decisions had been completed. However, it was not always clear how the assessments had been made and they simply had a statement saying that people would be unable to make the decision. Some best interest decisions which had been agreed were not being followed. For example, one person was assessed to sit in a supportive chair which restricts their ability to move independently. We saw that the person did not sit one of these chairs. A second person also had a best interest decision in place to sit in this type of chair and to be moved while still sitting in it. Again, we saw that they were not sitting in the chair as agreed.

When some decisions were made it was stated in the capacity assessments that family members had Legal Power of Attorney to make decisions for them. The provider had not asked to see these agreements to review what their legal rights were. This meant that they had not complied with guidance in the MCA and decisions may be made by people who did not have the legal authority to do this.

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

Staff had identified where there were restrictions in place and DoLS applications had been authorised. Further applications had been made which were awaiting assessment. When we spoke with staff they understood about DoLS being restrictions on people's freedom but they were not all able to tell us who had one in place and what it meant for that person.

Staff were not always adequately trained and supported to be able to support people well. When we spoke with staff about moving people safely they told us that they had received training in it recently. However, we observed practise which did not meet safety guidelines and neither care staff nor senior staff had recognised this as poor practise. Some staff had recently moved from one of the provider's different homes and they told us that they recognised that people's needs were different in this home; for example, that a lot of people had limited verbal communication and were living with dementia. They had not recently completed any training in dementia and had not been mentored by existing staff to understand people's needs. For example, there was a plan in place to support one person when they became distressed. When we asked one member of staff about this they said, "I don't know about a plan. I usually just ask the person to stop or

put their arms down and that seems to work". We reviewed the person's care plan and saw that there were techniques in place which included knowing about their background and engaging them in conversation about it.

People's healthcare needs were not always monitored and reviewed to ensure that they were kept well. For example, some people had diabetes and they should have had the sugar levels in their blood measured weekly. We saw that this was not completed and there had been up to one month's gap in the monitoring. This meant that the staff did not ensure that their condition was managed nor were they in a position to request additional medical guidance when it may have been required.

Staff did not always understand when people should be referred to other healthcare professionals to ensure that their needs were met. We saw that some people's mobility had decreased and that staff decided how to support them to move rather than refer them for an assessment. This meant that people may have been supported to maintain more independence if they had different equipment or if staff used different techniques. We saw that other people had fallen on a number of occasions and that the staff had not referred for guidance and support. This meant that staff did not always ensure that people's healthcare needs were met or that they had up to date guidance from specialists to inform their practice.

The environment was not planned to assist people to maintain their independence. There were no signs or pictures to help them to orientate; for example, to know what day or time it was. When one member of staff wrote what the meal options were on a board it was very small and there were no pictures or photos to assist people to understand. One relative we spoke with told us that they had asked staff to put subtitles on the TV so that their relative could follow the programme but staff had told them that they didn't think the television was able to do that.

Requires Improvement

# Is the service caring?

## Our findings

People were not always supported in a caring and kind manner. We heard people being spoken about in a way which did not respect their privacy. For example, we heard one member of staff shout down a corridor about one person's state of undress. We also heard staff speak to people in a strict manner. For example, we heard staff say to people, "Don't do that" and "Don't pull that down there". When some staff were supporting people to eat, they stood over them and did not engage the person in conversation or give them any encouragement but completed the task in silence. People drank from plastic beakers with lids on. We saw assessments for some people but others did not need this to drink safely. When we spoke with staff they told us that people drank better from those cups. This ahowed us that people's dignity was not considered when providing them meals and drinks.

People's dignity was not always upheld. When one person was in their bedroom and we saw that the room was cleaned around them including mopping under their feet. The person was not asked if it was okay to complete this task around them and they sat in a chair disengaged. Some people were distressed when the maintenance work was being completed and staff did not take action to relieve the anxiety; for example, by moving people to another room.

There were people who had a different cultural background and who spoke a different language and the provider had not ensured that they were able to express their choices about their care. For example, one person spoke only a small amount of English and could only speak their own language when a relative visited. This meant that for periods of weeks at a time they were unable to understand people or say how they would like to be supported. The provider had not ensured that the person's race, including their language, had been considered in upholding and maintaining their dignity in line with their human rights.

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

When we spoke with people's relatives they told us that they could visit when they wanted to and were always welcomed by staff. One relative told us, "I have been visiting for a long time and I come most days. I make myself at home and the staff are good to me".

Requires Improvement

# Is the service responsive?

## Our findings

Staff were not always responsive to people's changing needs. For example, we saw that one person was not sat in the chair that they had been assessed for. This meant that their feet were not supported and we saw that one foot was swollen. We raised this with staff who found a footstool. Later, we saw that this stool was not effectively supporting the foot and remained swollen. We intervened again to request that a different arrangement could be made. This was followed up by staff who provided a more substantial foot rest. This demonstrated that staff had not taken action themselves to relieve the person's discomfort. Another person was slipping down a chair and was at risk of falling. We spoke with staff about this and it was agreed that they should try some cushions to keep the person more comfortable and upright.

People had care plans in place which were not always up to date and sometimes contained conflicting information. For example, one person was observed to have limited mobility and to require assistance from staff to help them to move. Their care plan stated, '[Name] walks around the home and should be reminded to sit to rest'. Another person's care plan stated in one part that they had thickened drinks and at another that they drank normal fluids. When we spoke with staff they were unsure which was correct. Staff agreed that the care plans did not contain up to date information about people. This put people at risk of inconsistent care and meant they may not receive the support that had been agreed.

People did not always receive care which was planned to meet their individual needs. For example, staff knew that people may speak a language other than English and were watching television which they may not understand. Alternative programmes or music in their first language had not been explored. One member of staff told us they used flash cards to help them to communicate but recognised these cards were written in English and did not include any pictures to support communication and understanding. Another person had demonstrated a preference for moving independently in an individual way; this had not been taken into account when assessing their needs or planning their care.

We saw that staff spent some time with people throughout the day engaging them in activities such as reminiscence and games. People enjoyed these and joined in; for example, they pointed at photographs and told staff where the next domino should go. When we asked staff about activities they were unsure what had been planned and there weren't specific staff to oversee this. Activities and engagement had not been planned for people who were in their bedrooms and we saw that they had little interaction with staff other than to have personal needs met.

There was a complaints procedure in place and we saw that it was accessible for visitors on a board near the front door. The manager told us that they had not received any complaints and that on the advice of their recent quality monitoring review from the local authority they were improving their systems to include any grumbles or concerns that people or their families raised.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection we found that the provider needed to make improvements to how people were supported to ensure that they were safe. At this inspection these improvements had not been made and we identified further improvements were needed. Some of the actions that the provider told us would happen had not been implemented. For example, at the last inspection they told us that they planned to move to a new pharmacy provider and that this would resolve some of the issues identified around medicines management. At this inspection we were given the same explanation.

Since our last inspection we identified significant failings at one of the provider's other homes which resulted in us taking urgent action to close that service. The issues related to managing medicines and assessing and monitoring risks to people to ensure that their healthcare needs were met. At this inspection we found similar concerns at this location. The provider was not able to demonstrate to us that they had implemented any changes or systems into this service as a consequence of the highlighted concerns at their other nursing home. We found that the systems and audits in place at this service to monitor and improve quality were not effective.

There was not a registered manager in place. There was a manager who had been in post for four months and had previously worked as a bank nurse for some years. They told us that they were a registered manager for another provider for half of the week and they worked as a manager at this service for the other half. During that time they worked for some for the week as the nurse providing healthcare support to people. They said that this meant that they had two days where they oversaw the administration of the service. They told us that they were responsible for completing the audits and implementing new systems during this time. It is a condition of the provider's registration with us that the service has a registered manager who has the time and capacity to complete the role sufficiently. Therefore the provider was not meeting the conditions of their registration.

Audits to monitor medicines management did not pick up any of the concerns that we highlighted. We saw that weekly medicines audits had been completed which stated, 'No issues'. When we spoke with the manager about some of the omissions they told us that they had noticed one and administered the medicine the next day instead. They had not followed up with the staff member whose responsibility it had been. They had not completed an error report or recorded it on their audit. We saw that some of the MAR were hand written and that the guidance was not specific about administration. This had not been highlighted through the audits. It did not meet the Nursing and Midwifery council standards for medicine management. These state that if the MAR is hand-written the responsible member of staff must ensure that the charts are checked and signed by another competent health professional. This demonstrated to us that the audits were not completed in detail or were not completed by staff who were competent to do so.

There was not accurate, up to date complete care records kept for each person who lived at the home. We saw that care plans were checked on a regular basis and 'No changes' was recorded. When we spoke with staff and met some of the people who lived at the home we were told, and saw, that for some people there had been significant changes in their wellbeing. This demonstrated to us that care plans were not effectively

reviewed or audited to ensure that the information was up to date and accurate.

When we spoke with the manager about people's health they were often unable to tell us the overview that should be maintained. For example, we were not told at the beginning of the inspection how many people had pressure wounds and this was information we had to ask other staff for. We found that three people had been referred to healthcare professionals because they had lost weight. When we asked how many people had lost weight and were being monitored this information was not readily available. There was no system for monitoring it overall so that the manager could consider what improvements could be made; for example, reviewing the food that was provided. Reports were completed for accidents and incidents but they had not been reviewed for over one month. This meant that no attention had been given to trends that may have occurred or analysis of numbers of falls. We could not be assured that the provider had taken action to prevent further accidents when previous ones had not been reviewed.

The provider had not ensured that risks to people's wellbeing were managed by ensuring that they had the right equipment. Some people were assessed to need to sit in a specific chair which limited their movements and kept them safer. We saw that these chairs were not available to sit in. One chair was put into storage on the day of inspection and when we asked why staff told us it was because it was in poor condition and needed to be re-covered. It meant that people were at an increased risk of falls because they were not supported in the assessed way. The provider had also not assessed people to ensure that they had the equipment they needed to move safely; for example, staff told us that some people may be more confident being moved in a stand aid rather than a hoist but this had not been considered.

There had recently been a review by the quality monitoring team of the local authority and the manager was able to tell us what actions they were taking to meet the improvements identified. For example, they had fitted the new fire doors on the day of inspection. However, this had been highlighted on the provider's risk assessment eleven months previously and work had not been organised until it was highlighted by the monitoring report. The report was completed one month prior to the inspection visit and it had recommendations about people's care plans and PRN protocols. No immediate action had been taken to ensure that the information was now up to date.

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

Leadership within the home was not always effective in ensuring that staff understood their roles and were equipped to support people effectively. When we spoke with the manager about systems or people's wellbeing they often had to refer to a senior member of staff. Similarly, when we asked staff for explanations about people's care they were not always informed of why decisions were made and needed to refer to other staff. They had been included in a recent team meeting but had not had any meetings as a team for some time prior to that. They had not met as a team to discuss improvements or learning from the provider failings at another home and when we spoke with staff they recognised that it would be helpful to have those explanations and conversations.

The provider is required to display their latest CQC inspection report at the home so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating as required. They notified us of some important events that occurred in the service which meant we could check appropriate action had been taken. However, because other incidents had not been considered as needing reporting, for example as safeguarding concerns, we were also not always notified of these in line with our regulations.

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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br>People were not always treated with dignity and respect including paying due regard to their protected characteristics (defined in the Equality Act 2010) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br>Care and treatment was not always provided with consent from the relevant person. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br>People were not always protected from abuse and improper treatment |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br>People did not always have their nutritional and hydration needs met. |

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and treatment was not provided in a safe way to meet peoples needs. Risk was not always assessed, mitigated and managed to protect people. Medicines were not always managed to reduce the risks associated with them. |

**The enforcement action we took:**

We imposed a condition on the provider's registration to restrict admissions to the home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>.The systems and processes were not effective in providing good governance. |

**The enforcement action we took:**

We imposed conditions to the provider's registration to ensure that management systems were in place and effective