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Ashley Manor Nursing Home - Southampton

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 7, 8 and 11 January 2016 and was unannounced.

Ashley Manor Nursing Home provides accommodation and nursing care for up to 45 older people. The home is in a rural location near Shedfield, and provides accommodation on three floors. At the time of our inspection 20 people were using the service.

Ashley Manor Nursing Home did not have a registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Following our inspection in August 2015, we served a legal notice to deregister the registered manager. The provider had recruited a new manager who had started in post on 4 January 2016. The new manager had not yet registered with CQC.

At the last inspection on 10, 11 and 12 August 2015, we judged the home to be 'Inadequate' and as a consequence placed the home into 'Special measures'. This means that CQC keep the service under review and re-inspect within six months. There is an expectation that there will be significant improvements during this time. The provider was asked to provide a detailed action plan as a result of the August inspection and supply weekly updates of the action plan to CQC. The provider complied with this request.

The administration of medicines in the home was unsafe. The provider had introduced a new medicines administration system which started on 4 January 2016. Between 4 January 2016 and 10 January 2016 we identified 73 gaps in MAR charts. None of the errors had been detected by nursing staff who had signed to state they had checked the MAR charts. None of the errors had been reported to CQC or the local authority as a safeguarding concern. These errors included medicine for pain relief and chronic illnesses and would have had an impact on people's health and wellbeing.

All nurses had received up to date medicines administration training since our last inspection in August 2015 and had their medicines administration competency checked. However we found that nurses were not competent in the administration of medicines due to the numerous errors, which had been made, not identified, not rectified and not reported.

Nurses competence to administer medicines had been assessed, but records did not demonstrate competent actions to safely administer people's medicines. Oxygen cylinders were not stored safely, placing people and others at risk of harm.

Some areas of medicine storage and disposal had improved since our last inspection. For example, medicine storage temperatures were recorded and monitored.

Care plans included risk assessment tools to assess people's individual risks such as the risk of malnutrition. However it was not clear that all identified risks were being addressed and that assessments were regularly reviewed and updated in relation to people's changing needs. For example people being nursed in bed were at high risk of acquiring pressure ulcers. There were no plans in place to ensure people at risk were repositioned regularly to reduce this risk.

Staff rosters were planned to meet the inflexible working hours of nurses and to ensure staff worked their contracted hours. This resulted in a high ratio of staff to people. However effective care was not delivered as staff did not work efficiently or as a team.

Recruitment and induction practices for permanent staff were not safe. The records of three recently recruited staff showed gaps which demonstrated that the provider could not be sure that staff recruited were suitable for the role. For example full employment histories had not been obtained. This placed people at risk of care being provided by unsuitable staff.

During the inspection we identified safeguarding concerns which should have been identified by the provider, appropriately investigated and reported to CQC and the local safeguarding authority. These included missed doses of required medicines, over doses of medicines and development of pressure ulcers. This was unsafe for people. The provider could not be assured that people were protected from abuse.

There were improved infection control procedures since our last inspection in August 2015, however people remained at risk in relation to infection control. For example, we found one person's room to be dirty, their mattress and clothes were stained. Topical medicines did not have the opened date recorded. NHS guidance stipualtes that topical medicines should be disposed of three months after opening due to the risk of contamination.

Food and fluid charts had improved, however adequate monitoring of food and fluid intake was not taking place. Fluid charts were not totalled and although signed by nurses, there were no actions or explanations recorded when people drank significantly less than their target. People at high risk nutritionally did not have their intake monitored and care planning did not address the risks. For example one person was consistently losing weight but there was no care plan in place to address the weight loss. The provider could not be assured people were eating and drinking sufficient amounts to meet their needs.

The provider did not comply with the requirements of the Mental Capacity Act 2005 (MCA) to obtain valid consent for care and treatment. Mental capacity assessments did not include best interest decisions and one person had been given bed rails without their consent.

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 service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the deputy manager had made appropriate applications for eight people living in the home.

Staff had not received sufficient training to meet people's needs. Training since our last inspection in August 2015 had focussed mainly around infection control and food hygiene. There were significant gaps in training in respect of mental capacity, fire safety and health and safety.

Not all staff received regular supervision meetings and appraisals to ensure they were adequately supported

in their role. Records showed that 13 staff members out of 37 had had a supervision meeting and no one had received an appraisal. We were told by the deputy manager that these had been planned for January 2016.

Healthcare professionals visited the home regularly. A local GP visited the home twice weekly in order to treat anyone who was unwell and made extra visits if there was an emergency.

We observed that some staff behaved in a caring way towards people. However, not all staff behaved in a kind and caring way and it was evident that the overall culture of the home had not changed, in that care staff did not put people's individual needs first. One person who was distressed and in pain was made to wait because nursing staff were waiting for care staff to provide care and support rather than provide the care themselves. It was reported that staff dismissed one person who said they were in pain. Staff walked into people's rooms without permission and removed items which belonged to people. There was no respect for people, their belongings or their wellbeing.

A welfare and activities co-ordinator had been recruited since our last inspection in August 2015. This had been positive for people as they had someone they could talk to directly about their concerns. Positive comments had been left in the comments book by relatives and friends of people living in the home. These included compliments about the revised lounge lay out and the relaxed atmosphere in the home.

Care planning was not responsive to people's needs. We continued to identify gaps in care planning and a lack of understanding and knowledge of care planning. Care plans were brief, lacked detail and didn't address the known risks. We identified gaps in care planning around the management of wounds and pressure ulcers, a lack of planning around diabetes, end of life care, dementia and mouth care. One person was put at risk due to the failure of staff to treat their pressure ulcers appropriately.

The provider had introduced a new handover system, however this had not been implemented by staff. A handover system is how information about people's current care needs is passed between staff on different shifts so that care continues seamlessly for the person. There continued to be concerns about staff knowledge of people's individual needs and how they ensured they responded to updated information passed to them during handover.

The activities co-ordinator had scheduled an activity for every day, however these were all scheduled for the afternoons. Although activities had been introduced since our last inspection there was very little variety or external input.

A number of complaints had been received since our last inspection. Responses although apologetic did not always reflect that an investigation had been carried out and appropriate actions taken as a result.

Whilst some improvements in care had been noted during the inspection, there was unhappiness and unrest amongst staff which impacted on people's care. We noticed that care staff and nurses did not work as a team providing seamless care for people. Nurses did not lead and direct care 'on the floor.' Nursing staff did not show respect for management or the provider. For example they failed to implement the provider's systems. Some staff told us they were being bullied, others were upset and it was clear that staff were in conflict with each other and the provider. Staff did not behave in a caring and professional way. Staff attitude and conflict impacted on people's care, as staff failed to follow instructions or take their responsibilities seriously.

Although some improvements had been noted since our last inspection, the action plan had not been effectively implemented and staff did not act in a professional and responsible manner. There was positive

feedback about the newly recruited manager who had been employed three days before the start of the inspection.

Notifications to CQC which are a legal requirement had not been made and further incidents were identified during the inspection which should have been reported to CQC.

The provider failed to display the latest CQC rating conspicuously and in a place which is accessible to people using the service.

There was a system of quality monitoring in the home, however we found this to be ineffective. Concerns identified during this inspection were not picked up or actioned as part of the audit process.

During our inspection we found a three new and nine continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we asked the provider to take at the back of the full version of the report.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not administered safely.

Risk assessments were not accurate and did not include all known risks.

Staff were nor deployed effectively to meet people's needs.

People were at risk because the provider had not followed regulations for the safe storage of oxygen.

Incidents of potential abuse had not been appropriately reported.

People remained at risk of infection because some rooms were not clean.

Is the service effective?

Inadequate

The service was not effective.

People's food and fluid intake was not monitored to ensure people had sufficient fluid and dietary intake to meet their needs.

Staff had not received sufficient training to meet people's needs.

The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 in obtaining valid consent.

Appropriate applications to safely deprive people of their liberty had been made.

A local GP visited the home regularly.

Is the service caring?

Inadequate

The service was not caring.

People were sometimes treated kindly, but were not always

treated with dignity or respect.

People's independence was not encouraged.

Staff did not provide care that was individualised to the person.

Is the service responsive?

Inadequate

The service was not responsive.

People's individual needs were not met because care planning was not complete, lacked detail and did not address people's individual requirements.

An activities programme was in place however activities did not always respond to people's needs and wishes.

The service did not respond appropriately to concerns raised by relatives, staff and people living in the home.

Is the service well-led?

Inadequate

The home was not well led.

There was not a positive culture in the home. Staff argued amongst themselves and did not prioritise people's care.

The improvement plan had not been effectively implemented.

Appropriate notifications about key events were not made to CQC. As a result CQC could not be assured that the provider had responded to these events correctly to ensure people's safety.

The system of quality monitoring was not effective, to ensure the quality of the service or drive through improvements.

Ashley Manor Nursing Home - Southampton

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 checked 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 7, 8 and 11 January 2016 and was unannounced. The inspection was carried out by two inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services. Our specialist advisor was a specialist in the care of frail older people living with dementia.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. We did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 16 people using the service and one person's relative. We also spoke with the provider, the manager, the deputy manager, three nurses, four care workers, the maintenance man, two chefs, the activities co-ordinator and a visiting GP. We reviewed records relating to seven people's care and support such as their care plans and risk assessments. Additionally medicines administration records for every person living in the home were reviewed and as well as 14 people's daily care records.

Not all people were unable to tell us about their experiences due to their complex needs, therefore we used other methods to help us understand their experiences, including observation of their care and support.

Inadequate

Is the service safe?

Our findings

The administration of medicines in the home was unsafe. The provider had introduced a new medicines administration system which started on 4 January 2016. As part of the new system two nurses checked the medicines against the Medicines Administration Records (MAR) charts at the end of each medicine round to ensure early detection of errors. However, between 4 January 2016 and 10 January 2016 we identified 73 gaps in MAR charts. These were gaps where a signature to confirm administration should have been included or a code to explain why the medicine was not administered as prescribed. Some medicine had been signed to confirm administration but the medicine remained in its container. None of the errors had been detected by nursing staff who had signed to state they had checked the MAR charts. None of the errors had been reported to CQC or the local authority as a safeguarding concern.

Some of the errors we identified impacted on people's healthcare. Two people had missed doses of a drug which had been prescribed to regulate their heart beat. One person had received an overdose of warfarin. Warfarin decreases the body's ability to form blood clots. This could have been dangerous for the person if they had cut themselves accidentally. Since the inspection, the manager has reported to us, a further overdose of warfarin and information about another person who received less than the required dose. An under dose of warfarin could lead to a risk of blood clots. NHS advice on administering a wrong dose of warfarin is to contact your GP or anticoagulant clinic for advice. This advice was not followed.

One person missed two doses of a medicine which was prescribed to control symptoms in relation to their Parkinson's disease. This medicine is time critical, as it controls the symptoms of Parkinson's, and the person may have experienced increased symptoms due to the omission. One person received six doses of a medicine between 4 January 2016 and 10 January 2016. This medicine had been discontinued by the GP on 31 December 2015. One person, who was found to be in pain on 7 January 2016, had not had their pain relieving patch administered on 4 January 2016 as prescribed. The patch was due to be administered again on 10 January 2016, but when we arrived to continue our inspection on 11 January 2016 we were told by the manager that the patch had been missed again. There was a risk that this person had experienced pain due to the omission.

Two people had missed doses of metformin. Metformin is a medicine used to control blood glucose levels in people who have diabetes. There was a risk these people may have experienced changes in their blood sglucose level. A nurse had signed to say she had administered a dose of a steroid to one person but the dose remained in its packaging. When asked, the nurse was unable to explain why she had done this. Steroids are used to treat inflammatory conditions such as arthritis. Another person had been prescribed antibiotics to treat an infection on 7 January 2016. On the 8 January we noticed that the person had missed two of the prescribed doses. The NHS website states 'It's very important that you see your GP if you have missed doses because of side effects or illness.' The GP was not informed about the missed doses.

All nurses had received up to date medicines administration training since our last inspection in August 2015 and had their medicines administration competency checked. However we found that nurses did not demonstrate competency in the administration of medicines due to the numerous errors made, not

identified, rectified or reported. The procedure for missed medication had not been followed by nurses. This included establishing the reason, informing the GP, completing an incident form, ensuring the manager was aware and recording actions taken in the person's notes. People's medicines had not been administered safely.

Medicines were kept in locked trolleys secured to the wall in a locked medicines room. Controlled medicines were kept in a locked cupboard in the medicines room. The storage of controlled medicines met regulatory requirements. Controlled medicines have the potential for misuse and are therefore subject to the Misuse of Drugs Act 1971. However, we found medicines held in preparation for people's end of life care had not yet been entered into the controlled drugs book. On 8 January 2016, a nurse told us this would be done straight away, however we found this task had not been carried out by the end of the day. There was a risk that these drugs could have been misappropriated.

Some people needed their medicine 'as required' known as PRN medicine. There were no PRN care plans in place. There was a generic protocol in place which described generally when and why PRN medicines were needed. However, there was nothing specific to each person describing their symptoms and explaining to staff when a PRN medicine should be administered.

The unsafe administration of medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

We found that the storage and disposal of medicines had improved since our inspection in August 2015. The temperature of the medicines fridge and the medicines room were recorded daily and both records showed that the temperatures recorded were within required limits. The provider had just commenced a new contract with a local pharmacy for the supply of people's medicines. There were still some issues which needed to be addressed such as the collection of medicines for disposal (although appropriately stored) and the collection of medicines which were no longer needed under the old system. The provider had identified these issues and was taking action to address them.

The provider had not ensured the safe storage of oxygen in line with regulations. There were four canisters of oxygen in the medicines room. Nurses told us they thought the canisters were empty. Even when used, a small amount of oxygen remains in the canisters which is why regulations are in place to protect people. Oxygen allows fires to start more easily and burn more fiercely. There were two more cylinders stored by the side of the stairs near the front door. Although we pointed this out as a hazard on 8 January 2016, they were still in position when we returned on 11 January 2016. We found there was no risk assessment in place for the storage and location of the oxygen, there were no instructions for the safe storage and use of oxygen and there was no evidence that staff had been trained in the use of oxygen. There were no warning notices on the door of the medicines room where the oxygen was stored indicating the location of oxygen for the emergency services in the event of a fire. There was no policy in place covering the ordering, receipt, storage, administration and removal of oxygen. This was unsafe for people and staff.

The unsafe storage of oxygen was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

Care plans included risk assessment tools to assess people's individual risks such as the risk of malnutrition. However it was not clear that all identified risks were being addressed and that assessments were regularly reviewed and updated in relation to people's changing needs. For example some people were identified as at high risk of acquiring pressure ulcers. There were nine people being nursed in bed at the time of the inspection. This placed them at high risk because they were unable to reposition themselves regularly in

order to reduce the risk. Although this risk had been identified people's plans of care did not include information about how often they should be repositioned and daily records did not indicate that people had been repositioned regularly. Therefore, the risk of acquiring pressure ulcers had not been mitigated appropriately. Two people living in the home had pressure ulcers at the time of our inspection.

During our inspection in August 2015 we identified that wheelchairs did not have foot plates. We drew this to the registered manager's attention as foot plates protect people's feet from becoming entangled in the wheels, when the wheelchair is in motion, causing injury. During this inspection we noticed that wheelchairs were still missing foot plates. This continued to be a risk for those people who required a wheel chair to mobilise.

The failure to identify and mitigate risks to people was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

The provider had not used an appropriate tool to identify the number of staff required in relation to the number of people, people's dependency and the lay out of the home. Since our last inspection the provider had not taken steps to reduce the number of staff although the number of people using the service had reduced from 43 to 20. The deputy manager told us she planned staff rotas to "get staffs hours in" rather than to meet the needs of people. On the 7 January 2016 there were three nurses and six care workers deployed to meet the needs of 20 people. The deputy manager told us that there were not always three nurses on duty. She said that nurses were "inflexible" and would work only certain hours and shifts. Therefore they were rostered for shifts they chose rather than in line with people's needs.

Although a call bell printout for the period 4 January 2016 to 8 January 2016 did not indicate that people were waiting excessive periods for their call bell to be answered, we found evidence during our inspection that some call bells were out of reach and that staff were not deployed effectively to meet people's needs. On 7 January, we walked around the home at 10.30am. We observed that some people, who were not routinely nursed in bed, were still in bed. They told us they would like to get up. One of these people had told us at 9.30am that they would like to get up. At 11.30am they remained in bed, in their pyjamas. Another person told us at 10.25am that they were in pain and that they had been waiting for half an hour for a member of staff to help them. We noticed their call bell was not within their reach. The person also told us that their incontinence pad needed changing and they were distressed about the amount of pain they were in. A sign above the person's bed stated 'Please ensure I am sat up in bed.' We noticed the person was sloped awkwardly in bed. We called a nurse to assist the person who arrived promptly but decided that care workers were needed and went off to find them. During the wait for care workers the person became increasingly distressed. We were told by the deputy manager that all staff were helping other people and the person would have to wait. Given the high ratio of staff to people, this indicated that staff were not deployed effectively to ensure that call bells could be responded to appropriately. This wait was not recorded on the call bell print out because a nurse had responded and switched off the call bell when she was present in the room. However, she had not met the person's needs at that time.

Whilst there were sufficient staff on duty, they had not been effectively deployed to meet people's needs. This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Staffing.

Recruitment and induction practices for permanent staff were not safe. We checked recruitment records for three recently recruited members of staff. For one member of staff we were unable to find evidence that a Disclosure and Barring Service (DBS) check had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and

support services. The other two members of staff had not supplied a full employment history. The provider was unable to assure themselves that the three members of staff recruited were suitable to be employed.

The lack of safe recruitment procedures was a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Fit and proper persons employed.

Records showed that no staff had received safeguarding training since our last inspection in August 2015. In total six staff out of 43 were recorded as having completed safeguarding training. Out of those six people training had been completed between 2011 and 2014 and not refreshed since. Although staff said they were aware of safeguarding procedures and telephone numbers for staff to report concerns were displayed on a notice board, no safeguarding concerns had been reported to CQC since the last inspection in August 2015. During the inspection we identified safeguarding concerns which should have been identified by the provider, appropriately investigated and reported to CQC and the local safeguarding authority. These included missed doses of important medicines, over doses of medicines and the development of pressure ulcers. As a result CQC made referrals to the local safeguarding team, in order to keep people safe.

The lack of systems in place to protect people from abuse and to ensure that safeguarding concerns were identified and investigated was a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safeguarding service users from abuse and improper treatment.

There were improved infection control procedures in place since our last inspection in August 2015; however people remained at risk in relation to infection control. For example, the light pull cords in toilets and bathrooms were deeply discoloured. This meant that even after staff had washed their hands, when they turned the light off they would come into contact with an unclean surface and may be exposed to residual contamination. In one person's bedroom, we found a large white stain on the carpet at the entrance to the room. This had not been there the previous day and could not have been caused by the person residing in the room as they were immobile. This meant that something had been spilt on the carpet and not cleaned up appropriately. Additionally we found the person sitting in a chair with food debris around them, some of it trodden into the carpet. There was a white towel on the floor with a brown stain on it and the person had stained clothes. When we checked the person's bed we found the mattress protector to be dirty and the mattress inside the protector to be stained. There was an infection control risk for the person who was living in the room.

When people had been prescribed topical medicines, these were recorded on the MAR chart and all topical medicines were held in people's rooms. We checked ten people's bedrooms and found that open topical medicines did not have the date they were opened recorded. One opened topical medicine had been prescribed in 2011. There was a risk that this topical medicine had been open for years. The open topical medicines represented a risk of infection to people who used them, because staff could not be assured that they were safe to use. This put people at risk of infection because the longer the cream is open, the higher the risk of contamination from bacteria. NHS guidance stipulates that topical medicines should be disposed of three months after opening.

There were improvements in the cleanliness of the kitchen however we found that food in the fridge was not dated when opened. This included cartons of juice, soya milk, chicken paste, ham wrapped in cling film, prawn dip and cooked meat in foil. Safe storage of food reduces the risk of food poisoning. Kitchen staff could not be assured that the food was safe to eat because it was not recorded when the food had been opened.

We noticed that an electric wheel chair was very dusty underneath and did not appear to have been cleaned. We asked the person whom the wheelchair belonged to if they knew when their wheelchair had last been cleaned. They replied that their wheelchair had "Never been cleaned." This was an infection control risk to the person who needed to use the wheelchair on a daily basis.

The lack of recording of record keeping and ineffective cleaning regimes were a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

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Inadequate

Is the service effective?

Our findings

Food and fluid charts had improved since our inspection in August 2015. More information about the type of food eaten was included and fluid charts included a target. Although fluid charts were signed by nurses to confirm they had reviewed them, there was no evidence of any action taken when fluid intake was below target. Some fluid charts were not totalled so it was not clear that the fluid intake was below target. We reviewed fluid intake charts for five people who had not drunk sufficiently. None included total fluid intake in a 24 hour period. For example, one person's target fluid intake was 1,364 ml. We added up their recorded fluid intake for 5 January 2016. They had drunk 895 ml, which was 469 ml short of target. The chart was signed by nurses but no comment had been made about the adequacy of the fluid intake and whether any further action was needed. Another person had a target fluid intake of 888 ml. On the 6 January 2016 records showed they had consumed 200ml plus some sips. Again, these were signed by nurses but no comment had been made about the adequacy of the person's fluid intake in a 24 hour period. There was a risk that some people did not receive adequate hydration.

Although food intake was more accurately recorded, there was a lack of monitoring. For example one person had a pressure ulcer and their skin integrity care plan noted that the person should receive adequate nutrition. Food intake records for the person showed that the person had been consistently refusing at least one meal a day since the beginning of November 2015, yet there was no evidence that the person's food was being monitored by nurses for adequate nutrition and no evidence that any further action had been taken to support the person's nutritional intake. One person told us that they had been losing weight. Records showed that they had lost 19 kg in the last year. Their nutritional care plan written on 23 October 2015 noted that the person had difficulty eating due to broken dentures. During our inspection on 7 January 2016 the person's dentures remained broken and they continued to find eating difficult. The nutritional care plan did not note that the person had been consistently losing weight for a year and any action required to address the weight loss such as nutritional supplements. A care plan update on 8 December 2015 noted gradual weight loss but no action was recorded to address this. As noted during our previous inspection in August 2015, there had been no referrals to dieticians for people at risk nutritionally. The provider could not be assured people were eating and drinking sufficient amounts to meet their needs.

Steps had been taken to improve menu choice and records were improved in relation to people's individual dietary requirements. Records were kept in the kitchen which recorded people's preferred portion size, the consistency of food they required, people who required a diabetic diet and those people who required support to eat. However, the records were not kept up to date and still contained the names of a number of people who were deceased. One person was vegetarian. They complained that they were served too many vegetarian sausages. Records showed that on 2, 5, 6 and 7 January 2015, the vegetarian option was recorded as vegetarian sausages. The person's care plan indicated that they should receive a well balance diabetic diet. Records demonstrated that they were not offered a varied and balanced diet. Another person was recorded in their care plan as allergic to lactose. Records showed that they had been given ice cream and custard to eat. These products contain lactose. Some people's dietary needs were not adequately met.

Inadequate monitoring of food and fluids, the lack of care plans in relation to weight loss and the failure to

meet people's dietary requirements were a continuing breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Meeting nutritional and hydration needs.

The mealtime experience had improved for people since our last inspection in August 2015. Dining tables were placed in a distinct dining area and were laid with cloths, mats, cutlery and glasses. A handwritten menu was available on the table and there was wine for those who wanted it. Easy listening music was played in the back ground. Staff were observed supporting people to eat and they did so in a respectful and unhurried manner.

The provider did not comply with the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making specific decisions on behalf of people who may lack the capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. Where they lack mental capacity to make specific decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments had been carried out, which were decision specific, however, the provider demonstrated a lack of understanding of the MCA. For example, where it had been determined, by assessment, that the person lacked capacity, best interest decisions had not been made or recorded. This meant there was no outcome for the person and therefore the provider was not acting in the person's best interest. For some people it was recorded in their care plan that a relative had given consent for care and treatment. This is not valid consent. The person themselves should give their consent, and if they lack capacity to so the principles of the MCA should be followed. One person had given consent for a bed rail to be used on the side of the bed facing the wall. Two incident forms reported that the person had fallen whilst getting out of bed in the night. Following the two incidents, staff recorded that they had made the decision to use a bed rail on the open side of the bed. This prevented the person from getting out of bed independently. We saw the bed rails in situ and there was no record that the person had consented to this. Records showed the provider continued to misunderstand of the principles of the MCA.

Staff did not demonstrate a full understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Records showed that eight members of staff had received MCA and DoLS training since out last inspection in August 2015. Thirty two members of staff had not received training in respect of MCA and DoLS. Staff did not understand the principles of the MCA in order to obtain valid consent. For example, they used bed rails without obtaining the person's consent.

The failure to comply with the MCA was a continuing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Need for consent.

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 service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the deputy manager had made appropriate applications for eight people living in the home.

Staff had not received sufficient training to meet people's needs. There were 43 members of staff. Of these 19 had not completed or regularly refreshed moving and handling training, 35 had not completed first aid training and 16 had not completed infection control training. Food hygiene training had not been completed or updated by 22 staff and 31 staff had not completed safeguarding training. Some training had been completed since our last inspection and this had focussed mainly around infection control and food hygiene. Training remained inadequate for safeguarding, mental capacity, fire safety, health and safety and

person centred care.

Not all staff received regular supervision meetings and appraisals to ensure they were adequately supported in their role. Records showed that 13 staff had had a supervision meeting in November 2015. Thirty staff had not had a supervision meeting and there were no records which demonstrated that further meetings were planned. No one had received an appraisal however we were told by the deputy manager that these had been planned for January 2016. Staff were not adequately supported to carry out the duties they were employed to perform.

The lack of adequate training and support was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Staffing.

Healthcare professionals visited the home regularly. A local GP visited the home twice weekly in order to treat anyone who was unwell and made extra visits if there was an emergency. There was evidence in some care plans of the involvement of a speech and language therapist (SALT) although this was not consistent. A private physiotherapist continued to visit the home for those people who were able to pay for their treatment.

We noted during our previous inspection in August 2015 that the home was not well maintained and not appropriate for people living with dementia. Colours were bland throughout and room numbers were nearly indistinguishable being in small black lettering on a dark blue plastic plate. There was nothing to distinguish one bedroom from another or bathrooms and toilets from other rooms. This continued to be the case. However the provider told us that new signs had been ordered for everyone's room and there were plans in place for redecoration. The top floor had been cleared to facilitate this.

Inadequate

Is the service caring?

Our findings

We observed that some staff behaved in a caring way towards people. For example people were supported to eat in a kindly and patient way. A volunteer spent time reassuring people and talking with them about their lives and their families. However, not all staff behaved in a kind and caring way and it was evident that the overall culture of the home had not changed. For example one person in distress was unable to reach their call bell to summon help. Although they were initially visited promptly, they were expected to wait for a considerable time for the attention they required. Their concerns were rebuffed by the deputy manager. Records demonstrated that there had been a similar concern reported on November 2015.

On the second day of our inspection one person raised a complaint about the way night staff had behaved towards them. They said that staff had entered their room without knocking or asking permission and removed a wheelchair which belonged to them. The wheelchair was a key piece of equipment because they were unable to mobilise without it. The person tried to explain to staff that they needed their wheelchair, but were told by staff that they had spoken to them "Like dirt" and should apologise. Staff were not respectful towards the person or their belongings.

On entering a person's room we found that the person was wearing stained clothes, the 'bunching' of the continence product in use indicated that it was overfull and required changing, a stained towel was on the floor and the person was surrounded by food debris some of which had been trodden into the carpet. The person would have been unable to tread food into the carpet because they were not independently mobile. The person was not treated with dignity and respect. The person's call bell was not within their reach. We used the call bell to call staff to ensure the person was respectfully treated.

People continued to be given blue plastic aprons to protect their clothes when eating their lunch. The provider told us that this was people's choice and they were offered napkins or serviettes as an alternative. During our observation of lunch we did not see anyone being given this choice. They were put on people 'automatically' by staff. One person was being supported to eat in their room. We saw that staff had used an incontinence protector sheet tied around their neck to protect their clothes while eating. This was not respectful to the person.

A review of recent complaints included incidents which demonstrated a lack of respect for people. One person asked for a drink in the night and was told by staff that they could not have one, a member of staff got annoyed with a person who was unable to turn on their side when requested and a concern that care workers were not using napkins or serviettes. We witnessed another person being supported by staff in the lounge to alter their position. We heard staff say loudly and repeatedly "Move your bum up." This was not respectful to the person and was unhelpful as the person was unable to carry out the request due to their restricted mobility.

One person reported at a residents meeting that "The people here don't care, it's a job, and they want it as easy as they can." They gave an example that if a care worker was carrying a tray of dishes and someone needed help, the dishes would come first. The person had become very upset about this. Another person

reported that night staff were "rude" but was unable to clarify what they meant due to difficulties with communication. We discussed this with night staff. Both reported that the person rang their bell a lot in the night but neither said they had been rude. The night staff also told us that if people requested to get up before their shift finished at 8am they told them they had to stay in bed until the day staff came on shift. This was not respectful of people's choice. People were not treated as if their care was important.

The lack of dignity and respect for people were a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Dignity and respect.

A welfare and activities co-ordinator had been recruited since our last inspection in August 2015. This had been positive for people as they had someone they could talk to directly about their concerns. One person said "(The welfare co-ordinator) is good – she's trying to make it better for those who can't get around much." Records showed that people generally enjoyed their lunch although on one day the fish had been dry. Positive comments had been left in the comments book by relatives and friends of people living in the home. These included compliments about the revised lounge lay out and the relaxed atmosphere in the home. Personal histories had been included in people's care plans although it remained the case that people had not been included in their care planning. No one we spoke with could recall having their care plan discussed with them.

Inadequate

Is the service responsive?

Our findings

Care planning was not responsive to people's needs. Gaps in care planning had been identified during our inspection in August 2015. We continued to identify gaps in care planning and a lack of understanding and knowledge of care planning. Care plans were brief, lacked detail and did not address the known risks.

Although one person was immobile and unable to change their position independently, there was no risk assessment in place which indicated they were at risk of acquiring pressure ulcers. The person's skin integrity care plan stated that the person was able to tell staff if they felt sore and required repositioning. Regular repositioning as a method of preventing pressure ulcers is good practice and staff should not be relying on a person to tell them if they need repositioning. The care plan did not indicate that regular repositioning was required and daily records did not indicate that the person had been regularly repositioned. On 1 December 2015 an incident form reported that the person had 'black heels.' The person's heels would have started to deteriorate before they turned black but a review of records showed that staff had not recorded any concerns prior to this date. On 14 December 2015 a care plan was written to address the concerns identified on 1 December 2015. The care plan stated that the person had grade 1/2 pressure ulcers on both heels. This would have been an inaccurate assessment to make because until the black material on the heel is removed, the true depth cannot be determined. The care plan stated that the wounds should be kept clean, cream applied and monitored daily. There were no would wound care records showing the size of the wound and giving specific instructions for the care of the wound. There were no photographs of the wound so that it's progress could be monitored. There were no records which showed that cream had been applied daily and after the 16 December there were no records that the wounds had been monitored daily per the care plan. The person consented to showing our nurse specialist advisor their heels. Both heels were black and assessed by our specialist advisor to be at least a grade 3 pressure ulcer. The wound had not been treated appropriately; there was no appropriate care planning and the pressure ulcers had not been reported to the safeguarding authority and CQC per the regulation. The deputy manager told us that the person had been referred to the community tissue viability nurse (TVN), but when we contacted the TVN she said she had not received a referral. The person received inadequate care.

There were nine people being routinely nursed in bed, who were unable to independently reposition themselves and were at risk of acquiring pressure ulcers. Their care plans did not indicate that they should be regularly repositioned and daily records did not show that regularly repositioning had taken place. People were at risk of acquiring pressure ulcers.

At our last inspection we identified that there were no management of diabetes care plans in place. During this inspection we noted that diabetic care plans mirrored nutritional care plans and focussed on diet. There was no consideration of the other risks and concerns associated with diabetes such as skin integrity, eye care, foot care and how to identify and respond to a person if they became hypoglycaemic. A person becomes hypoglycaemic when their blood glucose level is too low. Previously there was no end of life care planning in place. These had now been completed for people; however they were brief, not individual and focussed on the period after death and not people's preferences about how they would like to spend the last few hours of their life. A high number of people were living with a cognitive impairment, yet there were

no management of dementia care plans in place. People living with dementia are affected in different ways and require different levels of support depending on the type and level of their dementia. There were no care plan for staff to follow to meet people's needs in respect of dementia.

Oral health affects general health, wellbeing and quality of life. The condition of a person's mouth and teeth affects their comfort and communication. Poor oral hygiene can lead to ill health. This is especially important for older people who are dependent on others for their care. The provider did not use oral risk assessments or care plans relating to oral health. People did not receive care in relation to their oral health.

The provider had introduced a new handover system. A handover system is how information about people's current care needs is passed between staff on different shifts so that care continues seamlessly for the person. The new system included a sheet giving information about people's key care needs such as the number of staff required to deliver personal care or assist the person to mobilise. We noted this sheet was not in use during handover on 7 January 2016 and during the handover process staff did not make any notes about the handover information being imparted to them. The provider told us that staff had found the sheet to be too 'cumbersome' and had chosen not to use it. There were care summaries in people's rooms but these were brief and lacked specific detail. There continued to be concerns about staff knowledge of people's individual needs and how they ensured they responded to updated information passed to them during handover.

The lack of appropriate care planning and delivery of care were a continuing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Person-centred care.

The activities co-ordinator had scheduled an activity for every day, however these were all scheduled for the afternoons. Activities were basic and included cards, a word game and dominoes. Five people attended the activity on the afternoon of 7 January 2016. External visits from entertainers, or visits to community events or venues had not been arranged. The provider told us that the activities co-ordinator visited people being nursed in bed, but people we spoke with were unable to confirm this. We asked one person whether staff popped in for a chat or to keep them company and they replied "Not much." Some activities had been introduced since our last inspection, but did not meet everyone's social needs or wishes.

A number of complaints had been received since our last inspection. Responses although apologetic did not always rdemonstrate that an investigation had been carried out and appropriate actions taken as a result. For example, one person complained that staff had been rude to them to them in the night when they were unable to comply with a member of staff's request to turn onto their side. They received an apology but there was no indication of an investigation with appropriate actions. Another person complained that they had been told by staff that they were not allowed to watch their television. Again an apology was given and a statement that the person should be allowed to watch television whenever they liked. There were a large number of complaints from staff about other members of staff which had not been investigated or responded to appropriately. This had led to unrest and unhappiness amongst staff.

Records in relation to a residents meeting included a number of concerns, which although discussed with the people raising them separately outside of the meeting, had not been properly investigated or addressed. For example one person said they were uncomfortable with some care workers and didn't like night staff. They also reported that after 8pm, night staff "badgered" them to go to bed. As a result of this night staff were reminded 'not to be rough.' Another person had reported that they had heard a buzzer ringing 252 times and observed a member of staff turning a call bell off because "they always buzz." Again there was no evidence that this had been investigated or appropriate actions taken.

The lack of response to complaints was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post, as a legal notice had been served by CQC to deregister the manager following the last inspection in August 2015. A new manager had only been recruited on 4 January 2016, three days before the inspection. The new manager was therefore unable to contribute to the inspection. She did however respond appropriately when concerns were raised during the inspection process. The deputy manager had been acting as manager between August 2015 and January 2016.

While some improvements in care had been noted during the inspection, there was unhappiness and unrest amongst staff which impacted on people's care. We noticed that care staff and nurses did not work as a team providing seamless care for people. Nurses had removed themselves 'from the floor' and were involved in administering medicines and writing care plans. They did not lead and direct care 'on the floor.' This had affected people's care, for example we observed one person had to wait for support while a nurse looked for care workers. The nurse did not see if as her role to support the person herself. Nursing staff did not show respect for management or the provider. For example they failed to follow medicine administration checks even though asked to do so and did not see the value in using a detailed handover sheet prepared by the provider, so this was rejected. During our inspection we noticed that nurses were not wearing 'Do not disturb' tabards which they are required to wear when administering medicines to ensure they are not distracted. The manager asked the nurses to wear the tabards and one nurse openly argued in front of inspectors against wearing the tabard because "It does not fit, it makes me look terrible." Nurses failed to follow instruction and procedures or see the value in working together as team to deliver high quality care. It was not clear to them that they should lead this care. Some staff told us they were being bullied, others were upset and it was evident that staff were in conflict with each other and the provider. Staff did not behave in a caring and professional way. On 8 December 2015 an incident form reported that 'both lifts have obscene graffiti.' This showed that staff did not have respect for the home. Staff attitude and conflict impacted on people's care, as staff failed to follow instructions or take their responsibilities seriously.

Following our last inspection in August 2015, the vision was for the home to improve. The provider had employed consultants to support this and prepared an action plan. However, the action plan was not effectively implemented and there was a lack of leadership in the home during this time. The new manager, although only present in the home a few days, had made a positive impression on staff. One member of staff told us "I think we all feel better that she is an experienced manager." Another said "It is early days but I think she will be good, there are all sorts of things she wants to bring in."

The acting manager had not recognised her responsibilities in implementing the action plan effectively and ensuring appropriate reporting to CQC. Notifications to CQC are a legal requirement and during our inspection we identified several incidents which had not been reported to CQC. Some of these had also not been reported to the local safeguarding authority. For example an incident on Christmas day was reported to the local authority but not CQC. Other incidents such as a missed pain relieving patch and pressure ulcers had not been reported to either CQC or the local authority.

The failure to report any abuse or allegation of abuse to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents.

Following the implementation of the rating system, providers are required to display their most recent rating conspicuously and in a place which is accessible to people using the service. On 11 January 2016 we noted that the provider had printed off a website report (which did not clearly show the rating for each domain). This was displayed on a noticeboard which was behind a propped open door and very close to a staircase. In order to read the rating we had to climb a few steps and lean over the bannister and behind the door. This was not accessible to people using the service.

The failure to appropriately display the rating was a breach of Regulation 20A of the Care Quality Commission (Registration) Regulations 2009, Requirement as to display of performance assessments.

There was a system of quality monitoring in the home, however we found this to be ineffective. Concerns identified during this inspection were not identified or actioned as part of the audit process. For example the infection control audit, recorded that food was stored appropriately. We found that food was not stored appropriately. The infection control audit also reported that pressure ulcers were dealt with appropriately. We found this to be an area of concern. The medicines management audit recorded, that there were gaps in recording, but no detail was included, there were no actions taken. This was an area of significant concern identified during our inspection but there was no investigation into gaps in MAR charts, as part of the medicines management audit. A catering audit recorded that no fresh fruit was available but no action was taken to rectify this. The audit dated 14 December 2015 recorded that people were offered choice, however the menus demonstrate that people were not offered food choices until January 2016. The kitchen audit showed gaps, in that a number of audit questions were not answered. For example, the question 'Are staff trained in COSHH?' was not answered. COSHH refers to control of substances hazardous to health. The laundry audit recorded that washing machines were not kept in a good state of repair with maintenance records available. There was no action recorded to address this concern. Care plan audits reported that care plans were 'compliant' however we identified gaps and a lack of detail within care plans. We also identified that key risks were not addressed and this was not identified during the audit process.

The lack of effective quality monitoring in the home was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Good governance