Clarendon Care Group Limited

Myford House Nursing & Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Myford House is located in Horsehay in Telford, Shropshire. The service provides accommodation and nursing care for up to 57 older people, some of whom are living with dementia. On the day of our inspection, there were 34 people living in the home.

The inspection took place on 14 and 15 August 2017. Day one of the inspection was unannounced, and day two was announced.

There was no registered manager at this service. A home manager had been in post for three months and had started the registration process with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

At our previous inspection in January 2017, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to good governance. At this inspection, we found the provider was still in breach of this regulation, as well as identifying four other breaches of Regulations. These were in relation to person-centred care; dignity and respect; safe care and treatment; and staffing.

People did not receive their medicines safely. Medicines were administered without being signed for, and without making the staff team aware they had been given. 'As required' medicines were given without a clear rationale for doing so, and without authorisation from the lead nurse. The nursing staff did not know how to safely administer one particular medicine.

People's risk assessments were not followed, which placed people at risk of harm and neglect. Staff were not always vigilant to changes in people's health, as per the risk assessments relating to their individual health conditions.

Where agency staff were used, they were not always inducted and supervised by experienced and senior staff members. Agency nurses were not supervised by the lead nurse, and the lead nurse had no oversight of clinical decisions made.

People did not always see health professionals when required. Their medical and health needs were not consistently reviewed. Changes in people's health and wellbeing were not responded to.

People's dignity was not upheld, including in relation to their personal care, appearance and hygiene.

The recording system used was unclear and unsafe. Important information about people's medication were

not documented or shared. Care records contained inconsistent information, making it difficult to ascertain what their needs were and how they had presented that day.

Staff did not feel able to approach management with any concerns, including safeguarding concerns and whistle-blowing. They felt fearful in their roles, and morale was low.

The manager and the provider had been unaware of some of the concerns we brought to their attention during our inspection, and these had not been identified as part of their internal quality assurance measures.

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; if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risk assessments were not followed, which placed them at risk of harm and neglect. People did not receive their medicines safely, and new agency staff were given the responsibility of administering these.

Is the service effective?

Requires Improvement

The service was not always effective.

People's changing eating and drinking needs had not been acted upon. The system used for weight recording was not always used effectively. People did not always see health professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Not everyone's personal care and hygiene needs were met. There was not always a dignified and respectful approach to people's appearance.

People enjoyed positive relationships with staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's changing health needs were not always responded to. There was an inflexible approach to arranging medical appointments for people.

People enjoyed a range of social and leisure opportunities. There was a system for capturing and responding to complaints and feedback.

Is the service well-led?

Inadequate

The service was not well-led.

The issues and concerns identified at our previous inspection had not been remedied. The recording system used was not being used effectively, which meant key information about risks posed to people were not shared and communicated.

Staff did not feel supported in their roles, and felt unable to approach management with concerns, including safeguarding concerns or whistle-blowing.

Myford House Nursing & Residential 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.

We made an unannounced inspection on 14 August 2017, and an announced inspection on 15 August 2017. The inspection team consisted of two Inspectors and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had knowledge and experience of care for older people.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service. This information helped us to focus the inspection.

Before the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We asked the local authority if they had any information to share with us about the care provided by the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We spoke with nine people who lived at the home and five relatives. We spoke with the Operations Manager,

the Operations Director and the Quality and Compliance Director (referred to as "the provider" in the report). We spoke with the manager, the deputy manager and 10 members of staff, which included one agency staff member. We also spoke with a GP. We looked at four care plans, which included risk assessments, healthcare information and capacity assessments. We looked at the six most recent medication error reports; medication administration records; two staff pre-employment checks; handover records; the adverse incident reporting system, and we carried out a stock check of a sample of three medicines.

Inadequate

Is the service safe?

Our findings

The registered provider has the responsibility of ensuring there are sufficient numbers of suitably qualified, competent and experienced staff, and that staff received the necessary supervision in their roles. People told us, and we observed that, staffing levels in the home were sufficient to meet people's needs safely. For example, people's call bells and requests for staff assistance were responded to promptly. However, we were concerned about the deployment of agency staff, and the lack of supervision in their roles. On the first day of our inspection, an agency nurse was responsible for administering people's medicines. It was their second shift at Myford House, and their induction on their previous shift had been carried out by another agency nurse, not by the lead nurse. The agency nurse member administered an 'as required' (PRN) medicine to two people, which was prescribed for the use of reducing anxiety. They told us they had not read either of the care plans; were unfamiliar with the PRN protocol; and had not discussed the matter with the lead nurse, who was on duty. They told us they had used their clinical judgement to determine the two people in question required their PRN medicine. One of the person's risk assessment said they were at increased risk of falls after their PRN medicine, and needed supervision. Staff were not made aware the medicine had been given, which meant they did not monitor and supervise the person, placing them at risk. The agency nurse was given the autonomy in their role to make these clinical judgements, despite them being unaware of people's needs and histories. They told us, "I have very limited knowledge of people's needs."

We asked the lead nurse about these PRN medicines and why they had been administered. The lead nurse was only aware that one person had been given this medicine, and was not aware of the second. They told us that for one of the people, "I have never known [person] have PRN in the time that I have been here." They told us that they delegated the medicine responsibilities to the agency nurse and had not maintained any clinical oversight during the shift; the manager was aware these duties had been delegated to a new agency nurse, and had not challenged this.. This left people at risk of not receiving medicines in line with their prescribed use. The lead nurse told us they did not understand why they had not been informed. However, they, the manager and the provider were responsible for ensuring that there were sufficient suitably competent and skilled staff deployed, and that they are supervised in their roles. They had failed to ensure the person with the responsibility to administer people's medicines was competent and experienced, and had not supervised them in their role. We asked the provider to address this issue and to ensure that agency nurses were given inductions by experienced staff, and were supervised in their roles.

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

As part of our inspection planning, we looked at the amount of medication errors which had occurred at the home in the last 12 months. We were concerned by the volume of these. We looked at the Medicine Recording chart (MAR) for the PRN medicines administered that day. The MAR did not reflect that these medicines had been administered as the nurse had not signed for these. By not recording this, people were at risk of being given further PRN medicine again that day, which would result in harm and adverse side effects.

We asked about what checks and assurances the manager and lead nurse regarding the medicines. They told us that they had discontinued the daily checks on the medicine trollies and that there was currently nothing in place. When we asked why this was the case, they told us that this was due to a positive medicines audit that had been undertaken by the local Clinical Commissioning Group (CCG) the previous month. There was no oversight of the amounts of medicines that were in stock. We carried out three random counts of people's boxed medicines. Whilst one count matched the number of medicines we would expect, the other two did not. One count showed that one person had not received their prescribed medicine three times since the beginning of August (a period of two weeks), this was even though the records indicated they had been administered. Another person for the same time period had one of the PRN medicines used to treat their anxiety missing. The nurse could not account for why the stock count showed inaccuracies. When we raised this with the provider, they were not aware that medicine checks were not happening and told us that they would reinstate this as a matter of urgency.

One person had epilepsy and was prescribed a PRN anti-epileptic medication. This medication is intended to be used during a seizure to cease the seizure. The medicine is designed to be given rectally and requires specialist training to ensure that this can be done safely. None of the nurses we spoke with had ever administered this medicine to the person for whom it was prescribed, nor had training around the safe usage of this medicine. This was not in line with current guidance over its safe usage. There was not a protocol for this person. This meant that there were no details as to when it would be administered and what other action needed to be taken to ensure the person was safe. All of the nurses we spoke with gave us different lengths of time they would give before administering the medicine. They also told us differing opinions over what action they would take if the person displayed signs of having an epilepsy seizure. This left the person at risk of significant harm if they were to have a seizure.

We looked at how the risks associated with people's individual care and support needs were managed. One person had a chronic respiratory condition, and a risk assessment was in place about how to care for this person safely. The assessment detailed that staff were to be vigilant to any symptoms of a chest infection, as well as to administer a prescribed homely remedy when symptoms were present. A homely remedy is a medicine which is available without prescription, and is used for the short-term management of conditions. This person had been unwell for a period of five days. One entry in the person's care notes stated the person was, "Constantly complaining about everything." No consideration was given to the person's condition, ill-health and risk assessment. We checked the person's homely remedy, and this had not been offered to the person since the point it had been prescribed, two months' ago. Staff we spoke with were aware this homely remedy had been prescribed, but were unable to explain to us why it had not been offered to the person to relieve their symptoms.

Another person had a heart condition and a pacemaker fitted. Their undated and unsigned risk assessment stated they were to have monthly observations of their condition, as well as referrals to the GP and pacemaker clinic. We asked the provider, the manager and the deputy manager who had completed the risk assessment, but no-one was able to answer this. This raised concerns over the provider's approach to risk management and keeping people safe. We asked to see the record of the monthly observations of how a person's heart condition was monitored. There were no specific observations recorded in relation to this person's condition, but there were two entries in July and August, titled 'general observations.' The records stated the person had refused to have their blood pressure taken on both occasions; no other observations were recorded, no evidence of referrals to the GP or the pacemaker clinic, nor were the manager or provider able to tell us how this person's condition was managed safely.

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

We checked two staff employment files to ensure the necessary checks had been carried out before they were allowed to work at the home. References and checks with the Disclosure and Barring Service (DBS) were completed and, once the provider was satisfied with the responses, new staff members could start work. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care.

Requires Improvement

Is the service effective?

Our findings

There were people living at Myford House who needed 1:1 staff assistance with their eating and drinking needs. We saw this assistance was provided, both during lunchtime and also throughout the day with snacks and drinks. However, not everyone's eating and drinking needs had been reviewed. For example, one person struggled to eat their meal. They told us they didn't want staff to help them and that was their choice. We mentioned to staff the person was having difficulty and asked if they were under the Speech and Language Therapy Team (SaLT). Staff recognised the person struggled with their meals, but said there was no current SaLT guidance in place. We looked in the person's care plan, and they had been discharged from SalT in December 2016. Although staff were aware there had been a change in this person's needs, there was no evidence that a new referral had been made. We brought this to the attention of the manager and the provider, who told us this would be looked into.

We looked at how people's weights were managed and whether concerns about weight loss or gain were acted on. The weight recording used was unclear. For example, one person had been weighed on 4 February 2017 and their weight had been logged. They were then weighed again on 10 February 2017, and the record stated, "Weight 0kg. Was weighed on the 6th February, was content." We raised this with the provider and the manager, who told us this was an error in the reporting. We asked to see this person's Malnutrition Universal Screening Tool (MUST) for February, but it was not available as had been archived. The provider told us there were no current concerns about this person's weight. We explained to the manager and the provider the importance of having a system which effectively captured changes to people's weight changes.

We spoke with staff about the ongoing training and support they received in their roles. Staff consistently told us more training and guidance was needed in relation to behaviours which challenge. The provider's adverse incident reporting system showed that incidents involving behaviours which challenge was the main area of concern in the home. Staff expressed concern that PRN medicines were given to people prematurely when they displayed behaviours such as aggression or agitation and that if they had more training and confidence in dealing with those situations, the use of PRN medication would decrease. Staff also told us the training they received from the provider was mostly online training, rather than face-to-face. Staff told us not all training was suited to this format, and there needed to be a mixture of practical training as well. They told us they had expressed this concern to the provider and were hopeful that improvements would be made. Our observations throughout our inspection assured us that staff were skilled at de-escalating behaviours which challenge.

People's healthcare information was detailed in their care plans. We saw people had access to a range of health professionals, including opticians, physiotherapists, and specialist nurses. However, as detailed elsewhere in this report, we had concerns that people were not always referred when they needed to be. We asked staff if they thought one person, who said they were unwell, should see the doctor. They told us, "Probably. Or they should go to bed for the day. I think they look more comfortable in bed." We asked the staff member why a doctor had not been called, and they were unable to explain this.

People told us they enjoyed the food provided, and that they had choices. One person we spoke with told

us, "The food is very good. They will always try to find you something you like." We saw that people were given individual copies of the menus for the day. The manager told us as part of improvements to people's dining experience, presentation of the menus was being looked at. The manager told us that since starting their post, they had placed emphasis on people being able to enjoy eating in a dining room, rather than just in the lounge or their bedroom.

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

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

Staff we spoke with had an understanding of people's individual capacity levels, including fluctuating capacity and how capacity was decision-specific. For example, one person was able to make day-to-day decisions such as what they wanted to wear and eat, but were unable to make larger decisions regarding their care and support. Where people lacked capacity to make decisions, these were made in their best interest by family members, staff and health professionals. For example, the best interest decision-making process had been followed in relation to one person and the use of covert medicines.

At the time of our inspection, people living at Myford House had been assessed in respect of their individual care and support needs, and the provider had ensured DoLS applications had been submitted accordingly. These authorisations were in the process of being reviewed to make sure they remained in date, were still appropriate and the conditions were being complied with. Staff we spoke with had an awareness of who had a DoLS in place, and what these restrictions meant for individuals.

Requires Improvement

Is the service caring?

Our findings

Before our inspection, we received information of concern about people's personal care and hygiene needs not being met. During our inspection, we noticed three people had dirty, long and splitting fingernails. We spoke with one person, whose fingernails had grown so long they had started to curve over. They told us, "They (fingernails) are too long, they are bothering me." We mentioned this to two staff members. One told us they would cut the person's nails that afternoon, but the other told us and their colleague that the nails had to be cut by the chiropodist. We looked at the person's care plan, and the last recorded visit by the chiropodist was on 18 August 2016- a period of one year. We raised this matter with the provider and the manager, who told us this was unacceptable and they would address nail care for people. No explanation was provided as to why the person had not seen the chiropodist for a period of one year.

A relative we spoke with expressed concern over the personal care provided to their relative at Myford House. They showed us photographic evidence they had taken of their relative's feet and nail care, as well as hygiene issues in the person's bedroom. The relative had raised these concerns with the manager and with the local authority. However, although concerns had been raised, the relative told us no action had been taken to improve the personal care their relative received.

On the second day of our inspection, one person was sitting in a chair wearing only one earring. We asked the person if this was their choice, and they told us, "No, I want to wear both earrings. I like my jewellery." They told us they had been wearing only one earring all day. Although a member of staff was sitting with the person at this time, they had not noticed the missing earring, nor had other members of staff. We raised this with the staff member, who then helped the person to look for it.

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

People had individual communication care plans in place. One person did not speak English as their first language, and their plan recorded they could become frustrated by not being able to communicate with staff. The plan recorded staff were to use the person's communication board with them, as well as liaise with the person's relative. However, staff we spoke with told us the communication board was not consistently used, particularly unfamiliar agency staff. They told us that other communication methods were needed, such as some staff doing a basic course in the person's native language. Two members of staff in particular were very keen to learn more about the person's language so they could help them to communicate and reduce their frustration. We discussed this suggestion with the provider and the manager for their consideration.

People told us they found the staff to be warm, friendly and caring in their approach, and we saw positive and respectful interactions between staff and people, as well as shared jokes and laughter. One member of staff chatted to people in the lounge about the one thing they would like to change about the world, with people sharing their responses and having a good-natured conversation about their views. We saw staff responded to people in a sensitive and calming manner. For example, one person suddenly became very

tearful and distressed. A member of staff quickly sat with the person and held their hand, which soothed the person and they stopped crying.

Requires Improvement

Is the service responsive?

Our findings

We looked at how people's changing health and wellbeing was responded to. One person we spoke with told us they felt unwell, and we saw they had a cough. We mentioned this to care and nursing staff. One member of staff told us, "Yes, [person] has a chesty cough and they are on the doctor's list for Wednesday." We asked what this meant, and it was explained to us the doctor routinely visited the home on Wednesdays. The person's care plan recorded the person had been seen by the doctor the previous week and their chest was clear. However, a period of five days had passed since that visit, with no further medical attention. We were concerned that staff we spoke with did not demonstrate an understanding of when and why it would be necessary to deviate from this routine approach. One member of staff told us, "We do call the doctor on days other than Wednesdays, but only when someone is really bad." The examples provided were of when people needed urgent medical attention, rather than when people expressed feeling unwell.This approach meant that people were at risk from not having their individual health and wellbeing needs responded to. We spoke with the GP, who told us the Wednesday visits were for check-up purposes and that they did visit the home on other days, as necessary; there were no restrictions in place regarding when the GP could visit.

A doctor's visit was subsequently arranged for the person on that day. However, on the second day of our inspection, the person told us, "I feel rotten. I am fed up with feeling ill." We asked the lead nurse and the manager how they thought the person was today. Both told us the person appeared "brighter" and that they felt better than the previous day. We expressed concern to the provider regarding a deterioration in the person's health. The provider spoke with the person and, such was the nature of the concern, requested the lead nurse to arrange an appointment with a specialist nurse, GP and the respiratory clinic. Following our inspection, the doctor had attended and prescribed antibiotics to address a change in presentation of the person's cough which was symptomatic of the person's health condition. The doctor was also considering use of oxygen therapy for the person. Neither staff nor management had identified the need for this intervention, nor responded to the change in the person's health.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We considered whether people's individual preferences were known and respected. Staff we spoke with expressed concern that breakfast times had changed, which meant people could eat breakfast from around 7.30am until around 9am. Staff told us that people were woken up to have their breakfast and that if people refused, there was not an opportunity later in the morning to have this meal. We asked what would happen if someone wanted to eat breakfast at 10.30am, and we were told they would be offered a drink and a biscuit, but not breakfast. We spoke with the manager about this concern, who told us breakfast times had changed, but that was with the view of making sure everyone was given the opportunity to have this meal. They told us people were not woken up, as the early risers were always served first. However, they told us they would look into this matter to make sure people had a choice over when they ate breakfast.

At our previous inspection, we found that people were not able to pursue their individual hobbies and interests. At this inspection, we found improvements had been made in this area and people had more

social opportunities. One person told us they had enjoyed playing balloon badminton that morning, telling us it was "a right laugh." Another person enjoyed knitting, and took part in 1:1 'knit and natter' sessions with the activity coordinator. We saw people had recently enjoyed trips out to local museums, cafes and garden centres, and a trip to RAF Cosford was being arranged as a group of people had requested this. For people who were nursed in bed or chose to spend time in their bedrooms, the activities coordinator spent 1:1 time with people to help prevent isolation.

There was a system in place for capturing and responding to feedback, suggestions and complaints. Where concerns or complaints had been made, these had been investigated and the outcome of this discussed with the person or people who had raised it. There was a new feedback box in the reception area for health professionals and relatives, which the manager told us would be regularly checked and any feedback reviewed. Residents' meetings were due to be established as another mechanism for ensuring people's views were heard.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not taken sufficient action to ensure their governance assessed, monitored and improved the service provided to people. The provider was asked to submit an action plan to outline how they intended to meet this regulation. Their action plan told us they would use audits to measure the care provided; complete observation competency of handovers; remind staff of the recording practices required, and review and monitor the adverse incident management system. At this inspection, we found the provider had not made the required improvements and remained in breach of this regulation.

At the time of our inspection, there was no registered manager in post. A new manager and a deputy manager had been in post for a period of three months, and the manager had started their registration process with the CQC. There had been a restructure in the provider's senior management team, with the appointed Operations Manager, Quality and Compliance Director and Operations Director being in post for a period of one month. The provider explained that due to this re-structure and the appointment of a new manager, they had not had chance to fully embed the improvements and changes they wished to make, and the home was still in a period of transition. We looked at the improvements made by the provider in this context of managerial change and instability. However, despite recognising the transition period, we identified significant concerns over the clinical governance and day-to-day management of the home.

We looked at the new electronic recording system introduced. The aim of the system was for staff to carry portable electronic devices which enabled them to record the tasks they had completed, as well as for reminder alerts to be sent to them to ensure they had carried out tasks such as repositioning and pressure care. We found this system was not used effectively, and neither the manager nor the provider could answer all our questions about people's care records. For example, one person's notes recorded, "Not available to have hands wash [sic]" before their meal. None of the management team were clear what this meant. Another person's notes recorded, "Had supper, ate nothing, had meal served in the lounge, food chosen was a balanced diet, was happy." We expressed concern that these notes were unclear and contradictory. A third person's notes recorded, "Refused to get undressed and threw coffee at staff, was content." The provider explained that some of the text on the system was pre-populated, which was why certain phrases were used. However, these pre-populated phrases used did not marry with what was being recorded. The provider agreed with our concerns and said the system was "chaotic." They told us they would take immediate action to ensure the systems used were streamlined and that information was recorded appropriately so they could identify and monitor any risks to people's health and wellbeing.

We looked at the handover system used. Of particular concern was that two people had received PRN medication, but this was not captured in the handover notes we were given. A handover is an opportunity for staff at the end of one shift and the start of a next to discuss any concerns or important information. One person's notes from the time-frame in which the medication was given stated, "[Person] enjoyed colouring in in the lounge, was happy." However, the nurse who had administered the medication told us they had done so as the person was distressed and agitated. It is essential that all staff are made aware at handover

of information regarding people's health and wellbeing, such as PRN medication given, so they know how to ensure people's safety. We were told by the manager that the handover notes we had, marked "shift handover", were not the handover notes used. They showed us a sheet they used, which was minimal in content and still did not reflect what we knew had happened that day. By not having a clear and effective handover recording system, people's needs could not be shared, monitored and responded to.

Staff we spoke with expressed concern that although they submitted incident forms to the manager, they did not know what action was then taken. We looked at the provider's adverse incident reporting system. We saw that trends and patterns had been identified since this system had been introduced, and we were told this would be shared with staff in the next staff meeting. Whilst we could see incidents were analysed, we were not satisfied that action had been taken to address all risks identified. For example, there was a pattern regarding agency nurses making medication errors. Although the forms recorded the action taken by the provider, there was a medication error by an agency staff member during our inspection. Action had not been taken to ensure the lead nurse had oversight of the medication administered and that all agency staff inductions were carried out by the lead nurse, rather than agency staff.

Staff we spoke with expressed low morale, and dissatisfaction with the home's management team. One member of staff told us, "It's horrendous. [Manager} doesn't want to hear it if you try to speak with them about any concerns. They tell you to make an appointment." Another member of staff told us, "The only time [manager] comes up here is to shout at us for not doing something." Although staff we spoke with were able to explain to us about recognising different types of harm or abuse, they told us they did not feel able to approach the manager of deputy manager with any safeguarding concerns, and would not feel comfortable in reporting any poor practice they observed. We made the provider aware of these concerns. Staff told us the deputy manager and manager were not visible on the floor, did not cover care shifts and did not carry out observations of people's care. We asked the manager about the observations they carried out, and they told us they looked at "everything." However, we were concerned that issues such as people's nail care and health needs had not been identified as part of these checks. There was no formal system of recording and structuring these observations. We raised this with the provider, who told us a new system would be introduced in this regard.

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

The provider had, when appropriate, submitted notifications to the CQC. The provider is legally obliged to send the CQC notifications of incidents, events or changes that happen to the service within a required timescale. Statutory notifications ensure that the CQC is aware of important events and play a key role in our ongoing monitoring of services.

We checked whether the provider had displayed the current rating of the home, and we found this was displayed visibly for people, in accordance with their regulatory requirements,