Bupa Care Homes (CFHCare) Limited

# Crawfords Walk Care Home

## Inspection report

Lightfoot Street
Hoole
Chester
Cheshire
CH2 3AD

Tel: 01244318567

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05 June 2017

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## Ratings

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

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

# Summary of findings

## Overall summary

This inspection was carried out on 27and 28 March 2017 and was unannounced on the first day. Following our inspection visit in March 2017, CQC received concerns regarding unsafe care and institutionalised poor practice undertaken at the service. A further unannounced visit was undertaken on the 5 June 2017.

Crawford's Walk nursing home comprises of four purpose-built units in the Hoole area of Chester. The service is owned and operated by BUPA care homes. Northgate is a unit for people with enduring mental health illness, Watergate and Eastgate are units for people living with dementia and Bridgegate unit provides support for those with physical health needs. At the time of our inspection there were 109 people living at the service.

At the time of our March 2017 visit the service was not managed by a person registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Subsequent to our visit the manager was successfully registered with CQC in April 2017.

At the last comprehensive inspection on the 16 and 17 May 2016 we identified a breach of Regulations 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and found that a number of improvements were required at the service. The registered provider did not have effective systems and processes in place to assess, monitor and improve the quality and safety of care. Consent to care and treatment was not always sought in line with relevant legislation. The registered provider was issued with a requirement notice for Regulation 11 and a warning notice for Regulation 17. We asked the registered provider to take action to address these areas.

At our subsequent focused inspection on the 8 and 9 August 2016 we identified a breach of regulations 10, 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and found that further improvements were required at the service. People were not always protected from the risk of unsafe care and treatment or supported or treated in a dignified and respectful manner. Staffing levels at the service were insufficient to meet people's needs and the skills and knowledge of staff to effectively undertake their roles required improvement. The registered provider was issued with a requirement notice for Regulation 18 and a warning notice for Regulations 10 and 12. We asked the registered provider to take immediate actions to minimise the risk of harm to people supported.

We told the registered provider they would need to meet legal requirements in relation to the breaches identified by 3 October 2016. This inspection found continued breaches of Regulation 10, 12, 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The CQC are now considering the appropriate regulatory response to the concerns we found. We will publish the actions we have taken at a later date.

People living on Bridgegate and Eastgate units were not always treated with dignity and respect. We identified continued institutional practices in place between the day and nights shifts. People's human rights and choices had not always been respected and this had not been identified or addressed by the registered provider. People's personal appearance was not always well maintained. Language used in care records at the service did not always afford people dignity and respect.

Staffing levels on all units were regularly assessed by the registered provider through the use of a dependency assessment tool. However, people told us and our observations showed that care and support during the day time was not always provided to people in a timely manner on Bridgegate and Eastgate units. Our visit on the 5 June 2017 identified that staffing levels on Watergate unit did not effectively meet the needs of people supported. Allocated 1:1 support hours on Eastgate unit were not fulfilled. This placed people at the risk of harm due to a lack of staff, reduced observation and support.

The quality assurance systems in place were not effective. We found continued issues as part of our inspection relating to the analysis of accident and incidents, accurate completion of supplementary charts and care records at the service. Information analysed regarding accidents and incidents was not always accurate or reviewed in line with the registered providers own timescales. There were no actions recorded to identify that the registered provider had considered risks, patterns or changes required to people's care needs. Quality assurance systems used by the registered provider had not identified issues we raised as part of this inspection.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. The registered provider had policies and systems in place regarding the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff practice on Northgate and Watergate units showed that consent was sought (where possible) from people prior to care being provided. However practice observed on Bridgegate and Eastgate units did not afford people the right to make decisions about their morning care routines. During our visit of 5 June at 6am we found that several people had been washed, dressed and placed back in bed. Records evidenced how people's capacity had been assessed and how decisions had been made in people's best interests in line with the Mental Capacity Act (2005). However, this information was not always adhered to or respected by staff.

People had access to regular drinks and food. The registered provider had supplementary records which were used to record food and fluid intake for people who may be at risk of dehydration and malnutrition. However, we found that charts were not always completed effectively or in a timely manner by staff. There were gaps of up to 20 hours where no food or fluid intake had been recorded. Information relating to what people had eaten was not always completed in detail to accurately reflect what they had consumed. Food and fluid charts were not consistently totalled to accurately assess whether people had received adequate food and fluids to protect them from the risk of dehydration and inadequate nutrition.

Personalisation of care plans had improved and records contained information about people's individual preferences about how they would like their care and support to be provided. However, we noted information relating to peoples preferred night routines was limited. Advice and guidance was sought from other professionals where appropriate to ensure that people remained well. However, records viewed did not always evidence how, why and what decisions had been made where people required the use of 'thickening agents' in their fluids.

New staff underwent an induction programme, which included training relevant to their role and shadowing experienced staff, until they were competent to work on their own. Staff confirmed they had received supervision and training in line with the registered provider's own timescales. We noted that mental health

training had not been provided to staff working on Northgate unit. The registered provider confirmed following our inspection that training had been accessed and dates had been arranged for staff to attend. However, observations of institutionalised practice during our visit on 5 June 2017 raised concerns with regards to the level of supervision, training and competency assessments undertaken by the registered manager and provider.

Health and safety checks had been carried out and equipment serviced. The service was clean and the manager and maintenance staff carried out regular checks of the environment to ensure it was safe. However, during our visit on the 5 June 2017 we noted that a fire exit on Bridgegate unit was blocked. We raised this with the registered provider and asked them to take immediate action to address this concern. Following our inspection the Fire authority confirmed that appropriate actions had been taken by the registered provider to minimise risk.

People or their family member's involvement in the review of care plans was not always clearly recorded. Care plans and risk assessments for four people living at the service had not been reviewed or updated following the receipt of important information or incidents that had occurred. Actions taken in response to changes had not been recorded by staff. The registered provider completed a review following our visit and provided us with updated care plans for these people.

Day staff morale had improved and there was a more relaxed atmosphere throughout the service. Discussions with night staff identified that improvements had started to be made, however the shortage of night staff continued to impact on their roles. We noted that staff who usually worked on days had been requested to undertake night shifts to cover staff shortages. Day staff were aware of the importance of encouraging people to maintain their independence and respecting their confidentiality. Family members said they had always been made to feel welcome when visiting.

The majority of people we spoke with said they were happy with the service that they received and that they felt safe. The registered provider had clear policies and procedures in place for reporting any concerns they had about the safety and well-being of people they supported.

Medication management on Watergate and Eastgate units was good. People received their medication as prescribed and staff were competent in the administration and management of medication. Medication administration records (MARs) were appropriately signed and coded for people's prescribed medication.

Staff had been employed following appropriate recruitment checks that ensured they were suitable to work in health and social care.

The service was managed by a person described as positive and approachable. People and their family members felt that there had been improvements made at the service since the introduction of a new manager. Systems were in place to seek people's views about the service. People and their family members gave feedback about the service they received, via 'resident's and relatives meetings'.

People and their family members told us that they knew how to raise a complaint and felt confident that the staff and management would act upon them immediately. The registered provider had a complaints policy and procedure in place and records showed that complaints had been dealt with appropriately.

The CQC were notified as required about incidents and events which had occurred at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in

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

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

## 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.

There was not always enough staff working on Bridgegate, Eastgate and Watergate units to safely meet the needs of people supported.

Accidents and incident records were completed at the service. However, robust analysis of incidents was not completed.

Care and treatment for people at risk of developing pressure ulcers was not always provided in a safe way.

Staff were recruited appropriately and relevant checks on their background were carried out. This ensured suitable staff were employed to work with vulnerable people.

People were assisted to take their medicines safely.

### Is the service effective?

**Requires Improvement**

The service was not effective

People were not always supported to have maximum choice and control of their lives.

People received support from staff who had completed appropriate training to undertake their role. However, assessments of practice and competency undertaken by the registered manager and provider were not always effective.

People had access to healthcare services as required.

### Is the service caring?

**Inadequate**

The service was not caring.

People were exposed to institutional poor practice which infringed on their Human Rights, care and well being.

People were not always treated with dignity and respect.

Language used in care records was not always dignified and respectful.

People's confidentiality was protected. Records containing personal information were appropriately stored in secure offices.

## Is the service responsive?

**Inadequate**

The service was not responsive

Food and fluid charts were not accurately completed, reviewed or analysed. People were not protected from the risk of dehydration and malnutrition.

Care plans and risk assessments were not always updated or reviewed as required. Night-time care plans contained limited information regarding peoples care preferences.

Records such as bed rails checks and daily mattress logs were not always completed in full detail, signed or dated.

There was a complaints procedure in place and this was made readily available to people.

## Is the service well-led?

**Inadequate**

The service was not well led

The registered provider had failed to meet the requirements of warning notices.

The registered provider's quality assurance systems were not effective.

The registered manager and provider had failed to identify and address continued cultural, institutional and restrictive practices at the service.

CQC were notified as required about incidents that had occurred at the service.

# Crawfords Walk Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the service on 27 and 28 March and the 5 June 2017. Our inspection in March 2017 was unannounced on the first day of our visit and the inspection team consisted of one adult social care inspector. On the second and third days of our visit three adult social care inspectors and an inspection manager visited the service. Our visit on the 5 June 2017 was an unannounced and took place at 6am in the morning.

We spoke with thirteen people who used the service and eight of their family members. We also spoke with seventeen members of staff, the home manager and area director. We looked at the care records relating to thirty eight people who used the service, which included, care plans, daily records, supplementary charts and medication administration records. We observed interactions between people who received support and staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in communal areas and staff interaction with people during a mealtime.

Prior to the inspection we reviewed the information we held about the service including notifications of incidents that the registered provider sent us since the last inspection, complaints and safeguarding information. We also contacted local commissioners of the service, prevention of infection and control teams and the safeguarding teams who had previously visited the service to obtain their views. They informed us that the service was continuing to make improvements to service delivery.

Inadequate

# Is the service safe?

## Our findings

The majority of people we spoke with told us they felt safe living at the service. They confirmed that they felt secure and knowing that there were staff available at all times of the day, made them feel safe. One person told us "I do feel safe in here yes, because I can call someone from my room if I need help or anything like that". Another person told us "I feel much safer here than I did at home, the majority of the staff are lovely who help me".

Following our inspection visit in March 2017, CQC received concerns regarding unsafe care and institutionalised poor practice undertaken at the service.

During our last focused inspection in August 2016 we identified a breach of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People living on Watergate unit were not always protected from the risk of unsafe care and treatment and staffing levels were not sufficient to keep people safe. We issued the registered provider with a warning notice and asked them to take immediate action. On the second and third day of our inspection we raised concerns with the registered provider regarding staffing levels on Bridgegate, Eastgate and Watergate units.

Records showed that staffing levels were based on a dependency assessment and care records evidenced that people's dependency was reviewed and updated regularly. This information was then used to determine appropriate staffing levels for each of the four units. The manager confirmed that staffing levels were reviewed following any new admissions at the service. This provided flexibility to review and amend staffing levels in response to changes in people's needs.

Our visit at 6am on the 5 June 2017 identified that appropriate staffing levels were not in place on Watergate unit. Staff confirmed that the unit was working with one carer less due to cover not being adequately arranged for annual leave. Inspectors found that there was one nurse and two carers on shift between 8pm and 8am. Further discussions identified that one person required 1:1support throughout the night hours due to a risk of harm to themselves and others. This meant that the care and support of 17 people, living with complex health needs, some of whom require two staff to assist them with their personal care would be carried out by the remaining one nurse and one care staff. This staffing level was not sufficient to meet the needs of people living on Watergate. This placed people at the risk of harm due to a lack of staff and reduced observation for other people living on Watergate.

The night staff on Eastgate unit consisted of one nurse and three carers. Inspectors were informed that one person required 1:1 support but this was during day time hour's only. During the handover procedure, discussions were held in relation to the allocation of an agency staff member for a person requiring 1:1 supervision. Inspectors queried whom the 1:1 allocation was for and were advised that another person living on the unit required 24 hour 1:1 support. Observations of practice between the hours of 6.10am and 8am evidenced that all staff on shift had been attending to people's personal care requirements and the 1:1 support had not been adequately provided as outlined in the person's care plan. Although the person came to no harm, these actions placed them at risk of harm due to lack of appropriate 1:1 observations.

Family members on Eastgate unit told us that at times the daytime staffing levels were very varied. They told us, "Sometimes there are lots of staff on shift and other times it's like skeleton staff and you are trying to find someone to help your relative. It can be very up and down" and "It's got a lot better, but there are times when there doesn't seem to be a lot of staff on duty". Staff confirmed that there had been times when they had been short staffed and they had tried to cover sickness or staff holidays within the team to ensure consistency of care. We shared these concerns with the registered provider.

Although we found that daytime staffing levels were in line with the registered provider's assessed allocation on Bridgegate unit, observations during our visit on the 28 March 2017 found that people did not always receive care and support in a timely manner. Discussions with people and their family members confirmed that staff did their best to meet the needs of everyone supported, but during mornings in particular there were not enough staff to help everyone. Two people spoke with us regarding having to wait to use the toilet for periods of up to 15 to 30 minutes, which had led to avoidable episodes of incontinence. We noted that family members visiting the service had gone to get food and hot drinks for some of their relatives as they had not received their breakfast at the time of their visit. We noted that breakfast service was still being undertaken at 10:50am.

This was a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014 as people were placed at risk of harm and receiving unsafe care and treatment as there was insufficient levels of staff to meet people's individual needs in a timely manner.

The registered provider had a policy and procedure in place to review and monitor accidents and incidents. Accident and incident records had been completed as required when events had occurred at the service. Records evidenced incidents such as slips, trips and falls and any injuries sustained by people. However, we found that where people had experienced regular falls, accurate information had not always been shared with the management team for their review and analysis. This meant that people were at risk of not receiving appropriate support in the management and prevention of falls. We have further reported on the analysis of accident and incidents in the well led section of this report.

During our last visit we raised concerns because records relating to the safe use of airflow mattresses were not in place. The required improvements had been made. People's skin integrity was monitored and a record of the findings was completed in detail. Care plans provided details of any equipment such as airflow mattresses and pressure relieving cushions which people needed to minimise the risk of them developing pressure ulcers. During our inspection people had the appropriate equipment they required in place and airflow mattress settings were correct. Care plans outlined how staff were required to monitor and check airflow mattress settings in line with people's weight. Health records evidenced that regular reviews by external agencies such as tissue viability nurses were undertaken. However, during our visit on the 5 June 2017 we found that records relating to repositioning for people identified as being at risk of developing pressure ulcers were not completed appropriately. 14 records on Eastgate and Bridgegate units had not been completed for period of up to 10 hours. Records for two people stated they required repositioning on a three hourly basis. Records were checked at 6.40am for both people and we found the last recorded entries on repositioning charts were completed at 19:20 and 19:25 on the 4 June 2017. Following our inspection the registered provider confirmed that both people currently had pressure ulcers. This meant that people were not being adequately protected from the risk of developing pressure ulcers.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as care and treatment was not provided in a safe way for people supported.

Previously we raised concerns because the emergency evacuation procedures for the service and

information regarding the level of support people required during an emergency was incorrect. The registered provider had a business continuity plan in place, which aimed to ensure that people were safely supported during an evacuation of the building. For example, in the event of a fire, flood, gas leak or loss of power to the service. Personal emergency evacuation plans (PEEPs) were in place for each person living at the service. Assessments identified specific levels of risk and what support individuals would require in the event of an evacuation. Staff knew where and how to access these documents in the event of an emergency. Records relating to fire drills and practice evacuations were in place and monitored by the manager and maintenance team. However, during our visit on the 5 June 2017 we found one of the fire exit routes on Bridgegate unit was blocked with an excess of furniture. The service practices horizontal compartmental evacuation. We raised this with the registered provider who advised that due to the current refurbishment of the service this may have been reviewed as part of the fire risk assessment. We requested a copy of the current risk assessment. This practice was not identified in the fire risk assessment for Bridgegate unit. We asked them to take action to reduce the risk to people in the event of an emergency. Following our visit we spoke with the fire authority who confirmed that they had reviewed this matter and the appropriate actions had been taken by the registered provider to minimise risk.

Observations and checks on Watergate and Eastgate units showed that people were supported to receive their medicines safely. One person told us "The staff look after my medicines for me. There are too many for me to manage now and I would forget to take them. They are very patient". All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administrating and disposing of prescribed medicines. Medication administration records (MAR) confirmed people had received their medicines as prescribed. Staff had access to important information about people's medication, including what the medication was for and any possible side effects. Procedures were in place for the use of controlled drugs and appropriate records were kept of these medicines. Staff who administered medication had a good knowledge of people's medicine needs and their individual medical history and we observed people being given their medication appropriately.

The safety of the building was routinely monitored. Records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and water temperature and quality were undertaken. The registered provider also had contracts in place for the routine maintenance and servicing of equipment. However, we noted that portable appliance testing (PAT) were not up to date. The registered provider confirmed that due to the current refurbishment of the service those checks had been put on hold and would be commenced following the completion of some of the work.

The registered provider had robust recruitment and selection procedures in place. Information contained in staff files demonstrated that appropriate checks had been carried out prior to them starting their employment. For example, for five staff recruited since our last visit we saw that an application form had been completed, evidence of formal identification had been sought and written references had been obtained. In addition a check with the Disclosure and Barring Service (DBS) had been carried out. These checks were carried out to ensure that only staff of suitable character were employed by the registered provider.

Staff members we spoke with had a good understanding of the different types of abuse and what action they needed to take if they had concerns. All staff confidently confirmed that they would report any suspected abuse immediately to the home manager or to external professionals if necessary. Policies and procedures in relation to the safeguarding of adults were in place and the actions staff described if they had any concerns were in line with the procedures. Records confirmed that staff had received safeguarding adults training. Staff told us they understood about whistleblowing and felt that they could raise any concerns and knew the procedure for this. Whistleblowing is where staff can raise any concerns inside or

outside the organisations without fear of reprisals.

Requires Improvement

# Is the service effective?

## Our findings

People told us they felt confident that staff would raise any concerns to external health professionals if they became unwell. Family members confirmed that if there had been any changes in their relative's health needs they felt staff had acted appropriately to seek advice and support.

At the last inspection, we had concerns about staff understanding and the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). We issued a requirement notice to the registered provider which identified that improvements to practice in this area were required. During our inspection visits we found that some improvement to records had been made, however, people were not always supported to have maximum choice and control of their lives.

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).

Policies and procedures were in place to guide staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff had completed training in relation to the MCA and they demonstrated an awareness of the principles of the act. Throughout our visits in March 2017 we heard staff asking people for their consent before providing care and support. Staff knew that everyone was assumed to have capacity unless they had been assessed otherwise. Where complex and significant decisions had been required to be made, care plans evidenced that formal capacity assessments and best interest meetings had been held with all relevant parties.

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. The registered manager had submitted applications under DoLS to the local authority for a number of people who used the service. These were for people they believed could not make a decision, due to mental capacity, as to where they should reside or the use of other restrictions in place such as locked doors or bed rails. Staff were aware that any restrictions should be properly authorised and always be the least restrictive option. However, practice we observed during our visit on the 5 June 2017 identified that a large number of people living on both Bridgegate and Eastgate units were not always supported to make decisions about their morning routine and when they wanted to get up. Information outlined in MCA assessments at the service relating to 1:1 support provision were not always adhered too by staff. We have reported further on this matter in the caring domain of this report.

As part of the registered provider's programme of induction new staff were enrolled to complete the Care Certificate. This is a set of 15 standards that social care workers complete during their induction and adhere

to in their daily working life. As part of their induction and following initial training new staff were required to shadow experienced staff. This helped to ensure they were familiar with people's care and support needs and people were not supported by staff they had not previously met. Newer staff members confirmed that they had their competency and skills assessed as part of their induction process. Once staff were assessed as competent and confident, they were able to work on their own.

Staff and records told us that regular training was undertaken to enable them to meet people's needs in a number of different areas relating to their role. All staff had undertaken training in areas such as moving and handling, food hygiene, fire safety awareness and the management of behaviours that may be seen as challenging. In addition further training in specified areas such as caring for a person living with dementia, pressure ulcer care and the safe use of bed rails had been completed. The manager had a clear view of the staff training needs and future development opportunities and ensured that these were regularly reviewed. However, we noted that training in mental health awareness had not been provided or undertaken by staff working on Northgate unit. We raised this with the registered provider who following our inspection sent confirmation of training dates with regards to supporting people with a functional mental health diagnosis.

The registered provider had amended their policy in relation to the supervision and appraisal of staff. The Area Director confirmed that Bupa had introduced supervisions on an 'as required basis' with a minimum amount per year to take place. Staff confirmed that they had started to receive regular supervision with the management team and this was sometimes completed in the form of group supervision meetings. They told us how they had the opportunity to discuss development opportunities within their current roles with the manager. Information relating to a management and development programme that some staff had been signed up to commence was shared with inspectors. Records confirmed that supervision sessions and group supervision meetings were completed in line with the provider's policy.

However, observations of institutionalised practice during our visit on 5 June 2017 raised concerns with regards to the level of supervision, training and competency assessments undertaken by the registered manager and provider.

People told us, "The food has improved here, you can't complain with what we receive to eat" and "It's very good most days, you will always have the odd time where it is not your cup of tea, but there is always something else available". We observed the lunchtime meal in the dining area on both Watergate and Eastgate units and the atmosphere was relaxed and calm. The lunch time meal was unrushed and people received the support they needed to eat their meal. Dining tables were well presented and condiments were available for people to use. Clear explanations and visual choices were offered to people. Staff members were observed to be sat with people at the dining table for the majority of time whilst they ate their meal and offered choices regarding food and fluids to the group.

Care plans described the support people needed to eat and drink including any specialist equipment people needed to promote their independence at meal times. For example, adapted crockery and cutlery. Jugs of juice were located around the service so that people or their family members could help themselves to drinks. Day staff ensured people being nursed in bed and those who chose to stay in their rooms had drinks in easy reach and they assisted people to drink as required.

The chef was observed to visit the units during our inspection to speak with people about the meals presented. He informed us that he consulted with people on a regular basis to ensure that menus (where possible) took into account individuals' likes, dislikes and preferences of food and drink. The chef confirmed that kitchen staff held information about people's specific dietary needs and were knowledgeable about them. For example kitchen staff were kept well informed regarding which people required a soft diet and

those who had diabetes and required a low sugar diet.

Staff identified for the majority of people when specialist input from external health care services, such as GP's, tissue viability nurses and speech and language therapists were required. Records of health appointments, including what was discussed and any actions decided were recorded by staff to ensure people received care and support that met their needs. Records showed that staff had taken appropriate advice from health professionals when required. Visiting health professionals confirmed that the service was 'good' at raising concerns that required input from a specialist.

At our inspection in August 2016 we raised concerns that the environment had not been adapted to meet the needs of people. The registered provider had commenced a programme of refurbishment across all four units. We were unable to effectively assess and review if the environment met the needs of people living at the service due to pending adaptations and decorations that were taking place. This will be reviewed as part of our next inspection process.

Inadequate

# Is the service caring?

## Our findings

The majority of people and their family members spoke positively about the care and support provided at the service. Comments included, "The staff here are very nice and friendly", "There has been a good improvement over the last few months" and "The majority of staff are very good". Family members told us, "It's a good service for [my relative]" and "There is always a happy atmosphere whenever I visit. There is good banter between [my relative] and the staff. That's very important to them".

At our last focused inspection in August 2016 we identified concerns that people living at the service were not always supported or treated in a dignified and respectful manner. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Dignity and Respect and we issued a warning notice to the registered provider.

Following our inspection visit in March 2017, CQC received concerns regarding institutionalised practice undertaken at the service. Our inspection visit on the 5 June 2017 identified ongoing concerns in relation to poor practice that infringed on people's Human Rights and examples of undignified care.

Inspectors identified that people living on Eastgate and Bridgegate units were woken, got out of bed, washed, dressed and placed back to bed. One person we spoke with when asked where they going to get up told us, "I was got up, I've gone back to bed now". The person was observed to be fully dressed under their bed covers. By 6:30am on Eastgate we found eight people back in bed fully clothed after having personal care needs attended to by staff. Staff confirmed that they had been advised by senior management following CQC August 2016 inspection visit to commence getting people up only after 6am. On Bridgegate unit at 6:05am we found six people had been washed and dressed. Two people were back in bed, one person was asleep in the chair in their bedroom, two people were in the lounge asleep and one person was being shaved and washed by staff. Staff on this unit confirmed that they commenced personal care, changing bedding and getting people dressed from 05:15am. Night staff we spoke with told us, "We try and do our best with what staff we have. We have had shortages of staff on nights and days. We try to make sure everyone has their needs met". This showed that cultural and institutional practices continued at the service which impacted on the care and well being of people supported.

People on Bridgegate unit told us they would use the call bell to alert the day staff, who would come and ask them what help they required. They confirmed that on a regular basis, staff would answer the call bell and inform the person that they were assisting other people and would come back to them shortly. They told us that on regular occasion's staff would not return for periods of up to 15 to 30 minutes, which led them at times to be incontinent. We observed at 11:10am on the 28 March 2017 that one person alerted staff attention by 'shouting' in a distressed manner that they had been incontinent in their bed through their bed clothes. The person stated to staff, "Look at me I'm soaked wet through" and confirmed that they were still waiting for help to get up that morning.

We asked day staff on Eastgate, Watergate and Northgate units about how they treated people with dignity and respect. Staff explained to us the importance of maintaining people's dignity and showing respect in the

way personal care was undertaken. Staff confidently described the importance of ensuring that people remained covered up as much as possible when receiving personal care, to ensure their dignity was maintained and they did not feel vulnerable or exposed. However, during our visit in March we found on Bridgegate that five people had not received adequate support to maintain their personal appearance. People had hair that was 'greasy' in appearance or not brushed and thick dirt was located under people's nails. This showed that people's personal appearance and personal care needs were not consistently maintained. We raised concerns regarding personal care on Bridgegate unit with the management team who advised us they would address them following our visit.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to recognise or address continued cultural and institutional practice within the service

Records evidenced that a 'bathing rota' was used on Eastgate unit. This rota identified specific days in the week where people would be allocated time to have a bath or shower. This is institutionalised practice. Care staff on Watergate when questioned informed us that they also thought they had seen this in practice. However senior staff informed us that a bathing rota was not in use. We raised this with the registered manager and registered provider who confirmed that they were unaware of this practice occurring and would take action to address it immediately.

Language used within care records was not always person centred. Some of the records written by staff indicated that staff lacked an understanding of how a person's condition might impact upon their mood or behaviour. We found entries such as "[person] is awake and screaming. It sounds like baby babble", "[person] has been up and down like a yo yo all night" and "[person] is aggressive and agitated" and "[person] is irritated today and in a bad mood". Records did not always demonstrate how staff supported people when they were feeling unhappy or unsettled. We spoke to the registered manager and provider about the need to ensure that records, as well as actions, afford a person dignity and respect.

This was a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as people's right to choice, respect and dignity were not respected.

The majority of people looked relaxed and happy in the company of the day staff who throughout our visit appeared attentive in their work. Observations showed that most staff took time with people and were kind in their approach and manner. Staff were observed explaining to people what they were going to be doing before offering support. Where people did not use the spoken word to communicate, staff continued to talk and explain what they were going to do to help the person. Staff across all units were observed knocking on people's bedroom doors and waiting to be invited into the room (where appropriate). This showed that staff understood the importance of respecting people's privacy.

There was evidence in people's rooms that they had the opportunity to have individual personal effects around them, including pictures and some items of furniture .One person told us, "I have brought all my important bits and pieces from home. They have helped me to feel settled here". A number of people commented they were supported by the maintenance person, for example to hang pictures. A family member told us "The handy man comes and checks everything to make sure it is all ok", another said, "The maintenance man is going to come and put photographs on [my relatives] wall. Their room has just been decorated, so it will be nice to get it all sorted and get them settled again". People told us that there had been some movement of rooms whilst the refurbishment was underway and that this had been managed 'quite well' to minimise any long term disruption.

Family members told us they felt they could visit or contact Crawford's Walk nursing home at any time of the day. They told us, "If I'm worried about [my relative] then I know I can give the staff a call and check how they are. It just helps me to relax at night". Observations showed that family members were welcomed throughout the duration of our daytime visits and offered refreshments as they sat and chatted to their relatives. One family member commented, "I get offered something to eat when I visit at lunchtime. It's nice that I can sit and have a meal with [my relative]".

Notice boards were placed throughout the service providing information for people supported and their family members. Information included activities taking place at the service, information on how to safeguard people and the complaints procedure. The registered provider had introduced a 'residents involved' feedback sheet which highlighted what actions they had taken in response to requests or questions asked by people living at the service. Requests such as 'A family member asked for a party for their relatives 80th birthday' and 'Can my relative have a TV in their room?' had been highlighted and the actions the registered provider had taken in response was displayed for people to read. This showed that the registered provider has listened and acted upon people's personal requests.

Where people did not have family members to support them to have a voice, the manager had a good knowledge of how to access local advocacy services. Information was readily available for people on how to access local advocacy services. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

The service had received a number of compliments since our last inspection visit. Comments included, "You made me feel very welcome when visiting and gave me the courage to speak up to make sure my husband receives proper care" and "You went above and beyond the call of duty for [my relative]. Thank you so much". These reflected that staff had at times treated people with kindness and showed concern for their wellbeing.

The registered provider offered support to people who were at the end stages of their life. The manager confirmed that at the time of our inspection in March 2017 that no one was receiving end of life care. Care records contained the relevant paperwork for those people who did not want to be resuscitated in the event of their death. This information was placed prominently at the front of the care record so that staff could easily access this information if they needed to. Staff were able to describe the importance of ensuring that people and their family members received dignified and appropriate support during this time.

People who used the service had been provided with information about the service and standards they should expect from the registered provider. Information included details of the registered provider and other key pieces of information such as how to make a complaint, confidentiality and maintaining people's safety and security. Records containing people's personal information were kept secure in a locked office. This ensured that people's confidentiality was protected.

Inadequate

# Is the service responsive?

## Our findings

People and their family members confirmed that they knew who to speak with if they wished to raise any concerns or complaints at the service.

At our comprehensive inspection in June 2016, we had concerns as accurate and contemporaneous records were not held in respect of people supported. This placed people at risk of receiving unsafe care or treatment. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the registered provider with a warning notice and told them to take immediate action to address areas of concern. Further action is required to be taken by the registered provider.

Food and fluid intake charts for six people living at the service were reviewed. Records for two people living on Watergate unit and two people living on Eastgate unit were not completed accurately and in detail and fluid intake had not been recorded in a timely manner. Records evidenced gaps of up to 17.5 hours where fluid intake had not been recorded. One person's chart recorded a total intake of 175mls of fluid over a 48 hour period, another person's charts recorded a fluid intake of 1190mls over a 48 hours period. The British Dietetic Association (BDA) guidelines state that over a 24 hour period the average intake for adults including the elderly should range between 1600-2000mls. In addition inspectors found that charts were not consistently totalled to accurately assess whether people had received adequate fluids to prevent the risks of dehydration. However, observations showed that people received and had access to regular fluids and there was no direct impact on people's health. The issue of accurately recording information relating to fluid intake was raised as part of the Regulation 17 warning notice issued to the Registered Provider following our comprehensive inspection in June 2016.

During our visit on the 5 June 2017 we found continued poor recording in relation to people's food intake. Supplementary charts for one person on Watergate identified as being 'at risk nutritionally' had gaps of up to 20 hours where no food was recorded as being consumed. Nutrition care plans stated the person should receive 'encouragement to eat snacks between meals'. No information was recorded as to the intake of snacks between any meals for 2 days out of 5 on records we viewed. Another person records identified that they required a fortified but low fat diet, this information is contradictory. Records evidenced gaps of up to 18 hours where the person's food intake had not been recorded. The person advised staff that they liked toast and jam, food intake records showed that there were 4 consecutive days where the person only had jam on toast to eat for their meals. Information relating to what food another person had consumed had been recorded as 'breakfast given', however the amount of food consumed had not been written on charts. People's health was placed at unnecessary risk due to lack of appropriate recording. People were not adequately protected from the risk of malnutrition. These omissions had not been identified as part of the quality monitoring system within the service nor as part of the registered manager's ongoing monitoring of the care provided at the service.

This was a breach of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as care and treatment was not provided in a safe way and accurate and contemporaneous records were not held in respect of people supported.

As part of the initial assessment of need, potential areas of risk for each person supported had been recorded. The majority of the risk assessments across all units identified specific risk factors and a plan had been put in place with instructions about how to manage the risks identified. Areas of risk such as mobility, pressure ulcer care, eating and drinking and distressed behaviours had been appropriately assessed. Family members confirmed they had been contacted and kept informed if a review of their relatives care and support needs had occurred. Care plans were reviewed on a monthly basis but we were told that people were not always involved in these reviews due to communication difficulties or lack of capacity. Senior staff confirmed that those who could participate would have their plans discussed with them, or family members would be invited to a review of care although this was not clearly documented. They explained in the event of a person's needs changing prior to the monthly review, care plans could be updated at any time to meet the needs of individuals. However, we noted that risk assessments and care plans had not been completed or updated for four people living at the service. Where important information had been shared regarding behaviours people may present or incidents that had occurred we found no recorded evidence of actions taken in response to update care records. We spoke with the management team at Crawford's Walk regarding these four people and following our visit we were provided with copies of reviewed and updated care records for each person.

In January 2017 the home manager had introduced a weight monitoring clinic which was attended by the unit managers and kitchen staff on a monthly basis. The clinic enabled the senior team to monitor if people had rapidly lost or gained weight and to review specific dietary needs and any specialist changes required or implemented by visiting health professionals. However, we noted that one person living at the service had lost a total of 8kg in a six week period in 2017. This person had not been considered as part of the weight monitoring clinic. Records we viewed did not clearly record decisions or actions taken in response to the weight loss. We raised this with the manager who confirmed that they would look into this immediately following our visit.

Records such as daily mattress checks and bed rail logs were not always completed in full detail. Information relating to the specific unit, month and year was not always recorded. Records were not always consistently signed and dated. This meant that there was a potential that records would not be able to be reviewed accurately in line with the registered providers monthly audits. We raised this with the management team who stated they would raise staff awareness regarding the importance of accurate and completed records following our visit.

Through discussions with day and night staff it was clear that most were able to describe people's character, routines, personal preferences, health and support needs. Care plans covered people's identified needs such as personal care, managing medicines and support with distressed behaviour. Care plans that had been reviewed gave an improved insight of how staff should best approach people's care and support. However, a review of records showed that the 'healthier happier care plan' contained limited information regarding people's personal preferences when being supported at night time. Staff confirmed there was no specific care plan that focused solely on night support and feedback had been shared with the registered provider. As evidenced during our visit on the 5 June 2017 people did not always receive care at night in line with their own personal preferences.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure that accurate and contemporaneous records were held in respect of people supported.

Consideration had been given in care plans about how to promote people's independence and to offer comfort and reassure people. Examples included in care plans reviewed stated, 'Try to encourage [name] to

be independent and wash themselves' and '[name] needs prompting to get washed and dressed. If [name] becomes frustrated you may need to talk them through the next steps to help them to focus'. However, practice we observed did not always mirror information contained in care plans. Each person's care plan contained a 'My day, my life' care plan which provided an overview of the person's life history and 'important to know' information such as likes and dislikes. These were completed to a variety of standards. We found some contained a good level of detail to enable staff to understand people they were supporting were as others held basic information and required further work. Staff confirmed that these were still work in progress.

People told us that activities at the service had improved. One person said, "I like the hand massages and beauty sessions we have". Another person told us that they liked it when the entertainers came and visited the service describing that time as "A brilliant atmosphere". Records showed whether people had been involved or chosen to observe activities that had taken place on each of the units. During our visit we noted that people on Northgate unit were happily engaged in a karaoke afternoon and staff had also participated in the singing. One person described it as "A great laugh" and "Good times". Other activities recorded included, balloon tennis, listening to music, walks in the garden and pet therapy. The manager informed us that the service would be commencing 'Namaste' as an engagement activity in the near future. Namaste is a bespoke programme of activity designed to improve the quality of life for people living with advanced dementia.

The registered provider had a complaints policy and procedure in place, a copy of which was provided to people and their family members when they moved into the service. All complaints received had been appropriately logged and dealt with by the registered provider. Following our inspection and due to concerns raised by people during our inspection the registered provider has engaged with the local authority. Independent meetings have been arranged to speak with people about the service. This evidenced that the registered provider wants to promote an open and independent culture at the service.

Inadequate

# Is the service well-led?

## Our findings

At the time of our March 2017 visit the service was not managed by a person registered with the Care Quality Commission (CQC). Subsequent to our visit the manager has been successfully registered with CQC in April 2017.

At our last comprehensive inspection we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the provider did not effectively use systems and processes to assess, monitor and improve the quality and safety of care. We issued a warning notice to the registered provider. This visit found a number of continued concerns relating to the effective use of the registered providers audit systems.

Information shared with the Home Manager and Area Manager as part of the registered provider's falls analysis toolkit was not accurately recorded in line with the accidents and incidents that had occurred at the service. The monthly 'location of falls' for two unit's recorded inaccurate information regarding two people living at the service. Records dated February 2017 for Watergate unit highlighted that one person had two falls during the month, however accident and incident records evidenced that five incidents of falls had occurred. Records dated February 2017 for Bridgegate unit identified that another person had two falls during the month, however accident and incident records evidenced that the person had fallen on four occasions. This information was used to present an overview of accidents and incidents within the Area Manager's monthly review with the Home Manager and was inaccurate.

Accident and incidents audits that occurred were not always completed in line with the registered provider's own timescales. A quarterly analysis of incidents had occurred at the service to establish any patterns or trends. However, the registered provider's policy and procedural guidance stated that a monthly analysis of this information would be undertaken in line with the falls analysis toolkit requirements. Records relating to three people who were identified as a high risk of falls and had encountered a combined total of sixteen incidents between January and March 2017 had no recorded action plans in place to evidence what actions had been taken to prevent the risk of repeated harm. Inspectors found inconsistent information recorded within the 'falls diary' and 'daily records for two of those people.

Audits completed at the service did not capture all of the issues we identified as part of our inspection. Where the use of undignified language had been recorded by staff in care records, we noted that each entry had been signed by a senior member of the team. This signature was in place to provide assurance that records had been completed and provided an accurate reflection of the care and support provided to people. However, we saw no evidence of constructive challenge with regards to the use of undignified language in care records. We identified four people whose risk assessments were not in place or had not been updated in line with information provided as part of the assessment process or in line with incidents that had occurred at the service. Ongoing concerns relating the accurate recording of food and fluid charts for people who were at risk of dehydration of malnutrition were not identified by the registered provider. Records relating to the repositioning of people at risk of developing pressure ulcers were not adequately maintained. This meant that the registered provider's internal audit systems were not effective.

Completion of records was discussed with the registered provider during our visit in March and they advised that they would ensure that all records would be completed in full and reviewed appropriately following our inspection. It is of concern that feedback given on 6 April 2017 to the registered manager and provider identified continued poor practice relating to record keeping in particular food and fluid intake charts, however similar concerns were found when we returned to the service on 5 June 2017. This demonstrates that the registered provider's quality monitoring systems are not effective.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered providers quality assurance audit systems were not effective or completed in line with the registered providers own timescales.

These issues of continued non-compliance were highlighted as part of the Regulation 17 warning notice issued to the Registered Provider following our comprehensive inspection in June 2016. The Registered Provider failed to meet the requirements and all elements of the Regulation 10, 12 and 17 warning notices.

Overall, people and their family members stated that the service had made improvements and they were happy with the care received. Family members told us they thought the management of the service was improving since the introduction of a new home manager in November 2016. One person commented, "I like the new manager, he seems really lovely and always listens to us". Family members told us, "He seems positive and approachable" and "Such an improvement".

'Residents and relatives' meetings had started to take place more regularly and during our inspection a relatives meeting was undertaken and was well attended. Family members told us that they were informed by the new manager when meetings were taking place and welcomed the opportunity to hold a discussion as a group face to face. One family member told us, "The meeting allows us to speak to someone there and then about anything that's good or anything of a concern. They have been welcomed" and "It's like being part of an extended family. We are all in the same boat supporting each other. That's why it's good to meet as a group". This showed that the registered provider understood the importance of listening and engaging with people and their family members to develop the care and support provided.

Minutes of previous resident and relative meetings showed that a range of items had been discussed, including the Christmas festivities, people's birthdays, complaints, cleanliness of the home and food. We noted that were areas of concern had been raised to the registered provider there was not always an action plan in place to evidence how issues had been addressed or resolved. We raised this with the management team who advised us they would complete this action in future meetings.

Staff confirmed that team meetings were now being held to discuss the service and also to ensure that important information regarding any changes to the service or practice were shared. Some of the areas that had been discussed included the findings from the last CQC inspection report, improvements to care plans, record keeping and auditing. Staff members spoke positively about the recent management changes and commented that for the first time in a long time they felt supported in their work.

The registered provider had introduced a 'Resident Care Booklet' in 2016 which included a comprehensive set of policies and procedures for the service. A copy of this was made available to staff in order to assist them to follow legislation and best practice and to ensure that staff had access to up to date information and guidance. Policies and procedures were regularly reviewed by the registered provider.

The service had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations.

The registered provider had displayed their ratings from the previous inspection in line with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20A.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect |
| Treatment of disease, disorder or injury | People's dignity was not always maintained and records were not always written in a dignified and respectful manner. 10(1)(2)(a)(b)(c). |

**The enforcement action we took:**

We issued a positive condition with regards to the dignified care and treatment of people living at the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The registered providers quality assurance audit systems were not effective or completed in line with the registered providers own timescales. The registered provider had failed to ensure that accurate and contemporaneous records were held in respect of people supported. 17(1)(2)(a)(b)(c)(d)(f). |

**The enforcement action we took:**

We issued a positive condition with regards to the management of effective governance at the service.