Care Quality Commission

Smallwood Homes Limited

Thelwall Grange Nursing Home

Inspection report

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Thelwall
Warrington
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Date of inspection visit: 23 July 2015, 3 September 2015,12 September 2105
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Ratings

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

Overall summary

We carried out an inspection on 23 July 2015 in response to information received from a whistle blower and Warrington Borough Council. During this visit we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We completed a further visit on 3 September to gather more information as a comprehensive inspection was required. A further visit was made on 12 September 2015. You can see what action we told the provider to take at the back of the full version of this report.

Thelwall Grange is registered to provide accommodation for up to 43 older people with personal or nursing care needs. Respite care is also offered. The home is situated within its own grounds in a rural location and has access to local amenities. There were 27 people living in the home at the time of our inspection..

Thelwall Grange has a registered manager. However, the registered manager advised us that he was working mainly at another home within the provider company

Summary of findings

and was intending to apply to deregister as the manager for Thelwall Grange. 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.

We found that a new manager had been appointed at the home and the current registered manager was supporting the new manager for some days each week. However, by the third day of our inspection we found that the new manager had left the home.

Sufficient numbers of staff were not provided to ensure that the home was cleaned to a high standard and that this standard was maintained. There were insufficient staff deployed in the afternoon and evening to ensure that the kitchen was fully staffed and the staff deployed in the laundry was on an ad hoc basis so clean clothes and linen could not be always available.

The standard of bed-linen at the home was poor and this needed replacing.

The hot water in the home in some areas was too hot and could cause scalding and harm. There were no hot water warning signs available. Water temperatures were not checked on a regular basis.

Radiators were excessively hot, measuring 67 degrees, and two people who were living with dementia were sat next to them. These radiators and others in the home had no radiator guards in place to protect people and when asked for risk assessments none were shown to the inspectors on any of the visits to the home.

There was no heating or hot water in the conservatory wing of the home.

Risk assessments were requested for a fire escape in a persons bedroom, however, these were not shown to the inspectors.

Risk assessments and care plans were not in place for someone on respite stay in the home. We found that care was not always provided in a way that met people's individual needs.

Equipment was stored in the under stair foot well. This was a fire hazard. A cupboard marked "danger lift machinery " was not kept locked.

We found that these concerns had not been rectified on the second day of our inspection

People who were at risk of losing weight could not be weighed as the scales were out of order. This issue was found at the visit on 23 July and at our subsequent visits on 4 and 12 September 2105 there were no working scales at the home.

Since our inspection the provider has confirmed that they have addressed some of the more urgent areas of concern.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We have been receiving action plans from the provider since our inspection.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found the service was not always safe.

There were inadequate numbers of cleaning, catering and laundry staff to ensure the home and laundry was kept clean and that care staff did not have to cook the main meal in the evening.

The hot water was too hot in some areas which could lead to scalding, no warning signs were in place.

Radiators in the home were too hot and had no guards in place. These had not been risk assessed.

No heating or hot water were available in some areas of the home.

Risk assessments were not in place for a fire escape in a person's bedroom.

Equipment was stored in stairwell obscuring the fire extinguishers.

Is the service effective?

Inadequate

The service was not always effective.

Staff spoken with had little understanding and knowledge of how to ensure the rights of people with limited mental capacity to make decisions were respected and supported.

We found one person who was being subjected to an unauthorised deprivation of liberty.

The home had no special design to support people living with dementia to find their way around.

Is the service caring?

Requires improvement

The service was not always caring

Some bedrooms were dirty and commodes had not been emptied by staff after use.

People and relatives said staff were friendly and welcoming

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

We found the service was not always responsive.

Care records were not always accurate and up to date to ensure that all staff were aware of the current needs of people living at the home.

People and their relatives said they would be comfortable about making a complaint if necessary and they had information about how to do this.

Summary of findings

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not carried out regular monitoring of the service.

Quality assurance tools in place did not highlight issues and concerns identified by CQC and Warrington Borough Council.

People, relatives and staff felt the manager was approachable.

Thelwall Grange Nursing Home

Detailed findings

Background to this inspection

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

We undertook this inspection on 23 July 2015 following concerns raised by a whistle-blower and from Warrington Borough Council. Due to concerns found at this visit a full comprehensive inspection took place.

The inspection was undertaken by one adult social care inspection manager and one adult social care inspector on the first day and two adult social care inspectors on the second day. Two adult social care inspectors visited on a third day.

Before our inspection we reviewed the information we held about the home and looked at the information received from the whistle-blower and reports from Warrington Borough Council contracts monitoring team.

During our visit we completed a full tour of the home including bedrooms, lounges, bathrooms and show rooms, the main kitchen and laundry. We checked the temperature of the hot water in the bedrooms and bathrooms we looked at. We looked at some care plans in relation to specific care needs that people had and spoke with people living in the home. On the second day of the visit we looked at training records, staff files, supervision records for staff and spoke with people living in the home, the registered manager, new manager, staff and people visiting. We raised concerns with the fire service and the infection control team. We also contacted Warrington Borough council contracts monitoring team.

On the third day of the inspection we checked to see if any improvements had taken place.

Inadequate

Is the service safe?

Our findings

We were informed by the whistle-blower and Warrington Borough Council that the home was not cleaned to a high standard and that the hot water in some areas of the home was too hot.

People who lived in the home were not always safe because there were a number of cleanliness shortfalls that compromised the control of infection within the home. Not all bins used for dirty waste were foot operated and did not meet prevention and control of infection guidance.

On the first day of our visit we found that some areas of the home were not clean and some areas were an infection control risk. For example, we looked in one of the bathrooms at 10am and found dirty linen on the floor and the bin had no liner, but a dirty incontinence pad had been disposed of in the bin. We revisited this bathroom several hours later and found that the same dirty linen had been draped over the laundry skip. The laundry skip did not have a bag in it. On the second day of our visit this bathroom was clean and dirty linen was in the linen skip, however, we found that there were still two bins present in the bathroom, one without a bin liner had again been used to dispose of dirty incontinence pads.

In a shower room on the first floor we found the shower curtain to be badly stained with mould and a shower mat which was very dirty. Another bathroom contained a bin with no lid. On the second day of our visit we found that the stained shower curtain and shower mat had not been replaced.

Following our visit we contacted the infection control team at Warrington to share our concerns around the poor infection control measures in place and the cleanliness of the home.

A visit was made to the home by the infection control team on 9 September 2015 and they asked the registered provider to take immediate action. When we visited for the third day we found that extra staff were on duty to deep clean and de-clutter some areas of the home.

We hand tested the water which ran from the hot taps at several points throughout the home. In a number of communal bathrooms, shower rooms and toilets the water from the hand basins was very hot and we were unable to put our hands underneath the running water. This meant that people living in the home, visitors and staff could scald their hands whilst washing them at the sink. There were no signs on display to warn people that the water was very hot. When we revisited the home on two occasions this had not been rectified.

We found the conservatory wing of the home had no hot water or heating and were informed that this had been going on for some time. A gas engineer was on site at the time of our visit and stated they had been at the home on at least three other occasions and were unable to rectify the problem. We saw from the meetings held with the registered provider and managers that this had been discussed on at least two occasions. On speaking with the registered provider via telephone we were assured that this issue would be rectified as soon as possible. Following our visit we received email updates as to how this work was progressing. To date this work has not been completed to ensure that people have access to warm rooms and hot water in which to wash or bathe. Some people have been moved to other areas in the home, where hot water is supplied.

We looked in one bedroom and found that the sash window was being held open by a book. The window was heavy and this could easily have trapped the person's fingers or hand, or indeed staff members or visitors fingers. There was no risk assessment in place with regard to this window. On the second day of our visit we found the sash window was being held open by a piece of pressure relieving equipment. On the third day we visited no changes had been made to the safety of this window and no risk assessment had been put into place.

One bedroom had a fire escape leading to an outside staircase; the door was propped open to let in some fresh air. We requested a risk assessment for this but none were given to us. We were told by the manager that the person in the room was unable to walk without assistance but she would put a risk assessment in place immediately as visitors or staff needed to be aware of the dangers of falling. When we returned to the home we found a risk assessment was in place for people living in the home but not for any staff or visitors that may go in to this room. The manager said she would update this immediately.

We found one person's bedroom to be extremely hot and the unguarded radiator was very hot to the touch. We requested a risk assessment but none were shown to us. A

Is the service safe?

risk assessment must be in place to ensure that the person was aware that they should not touch the hot radiator. There was no thermometer in place in this room to determine how hot it was.

We looked in both the sluice rooms at the home and these were unlocked and very dirty. Sinks were stained with faeces and we found mops were hung up, but these were dirty. Commode pots which had been emptied were dirty, flower vases were unwashed and in one of these sluices we found dirty clothes on the floor. We observed a staff member cleaning the corridor outside the sluice room but they did not go into the sluice room to clean it. On the second day of our visit we found no improvement to the cleanliness of the sluice rooms. We also found in the downstairs sluice room chemical disinfectants left on the worktop, the room door was unlocked which meant that people who lived in the home and visitors were not being protected from harm. These rooms also had extremely hot water with no signage to inform staff. On the third day we visited we used the cooks calibrated thermometer as to determine how hot this water was. We measured the water at 63.4 degrees Centigrade**.** This room was still unlocked.

We found in one bedroom that an electrical lead had been plugged in and was trailing over a sink. We informed the nurse in charge and they unplugged it and plugged it in elsewhere in the room.

We found that in an occupied bedroom a window was open, we found an electrical extension lead was plugged in and when we investigated this was leading to the building work outside the home. We discussed this with the manager who was unaware of this and stated that the builders had not been on site for at least three weeks. We revisited this bedroom on the second day of our visit and found that the extension lead had been re-plugged in to the socket. The person whose room it was living with dementia.

We saw that the main stairwell had a cupboard under it marked “Danger lift machinery”. This cupboard had a broken padlock on it so that anyone could have opened it. Stored near to this cupboard in the stair well were privacy screens, wheelchairs and pressure cushions. This constituted as a fire hazard. We checked this area when we returned to the home and found that the cupboard was still unlocked and further pieces of equipment and furniture had been left in front of the fire extinguishers so they could not be easily seen or accessed by staff in the case of an emergency. Following our visit we contacted the fire service to inform them of our concerns and they visited the home on 9th September 2015 and asked the registered provider to take urgent action. We visited the Thelwall Grange on 12 September 2015 and found the equipment had been moved but the lift machinery cupboard was still unlocked. A staff member went out and purchased a padlock for this cupboard whilst we were at the home.

On the third day of our inspection we found two people living with dementia and assessed by staff as at risk of falls were sat in the conservatory, unsupervised, next to radiators that were extremely hot to the touch. On measuring the temperature of both the radiators with a calibrated thermometer we found the temperature of one was 67.7 degrees centigrade and the other one was 64 degrees centigrade. There were no radiator guards on the radiators and there were no risk assessments in place to ensure that people were being kept safe from harm. We also found that the windows in the conservatory were open and had no window restrictors in place. There was no risk assessment in place to ensure the safety of people who may fall out of these windows.

The blinds on the windows of the conservatory had been taken down as they were filthy dirty. We found that there was no means to minimise the sun coming through the windows in to the faces of the people sitting in there.

We found that throughout the home people did not have access to call bell systems and had no means of calling staff for help. There were no risk assessments in place or directions for staff to check on these people more frequently to ensure that they did not need help or assistance or were kept safe. There was no call bell system in the conservatory.

One person whose bedroom was behind a locked door was unable to use the call system. When we checked the system in their bedroom it was found not to be working. This meant that if the person had fallen staff would be unable to call for help. This person, who was living with dementia, had access to a lounge area that had windows not fitted with safety glass and that extended from the ceiling to below waist level. There was no safety rail in place to prevent a person falling through in the event of a fall. This person was assessed as at a high level of risk for falls on risk 10/07/2015 and again 20/08/15. The RGN we spoke at the time of our visit told us that the person was not at risk of falls.

Inadequate

Is the service safe?

We found that one bedroom, which was unoccupied, had a window which was not fitted with safety glass, extended from ceiling to below knee level, and had no rail to prevent a person falling through in the event of a fall. This window had been broken and although there was a temporary repair with paper and tape there were sharp edges. This bedroom was not locked and people who live in the home could go in to this bedroom and be at risk of harm. We requested a risk assessment but none were shown to us.

On the third day of the inspection we spoke with the RGN on duty and the quality lead for the company. The quality lead informed the inspector that they did not know about potential hazards presented by heated surfaces and the RGN in charge was unable to inform us which service users were at risk of falls, even in the case of one person who they had assessed as at risk of falls on the 20/08/2015.

We were also informed that there was no staff deployed to work in the laundry and staff at the home were "picking up "extra shifts to cover this. We looked at the laundry and found that no washing or drying had taken place during the first day of our visit. The laundry was not clean, floors were dirty and clothes were left in a large laundry skip. The laundry smelt and was disorganised. Laundry premises must be kept free from the accumulation of dust as this constitutes a fire hazard. Following our inspection we contacted the fire service to inform them of our concerns. During our third visit we found a staff member had been employed to work in the laundry and it was much cleaner and well organised. The area behind the machines still needed a deep clean, however the surfaces were now dust free.

We looked at the care records for one person that had been on respite stay at the home. This person told us they had fallen when being assisted to use the bath. We found that there were no risk assessments in place to enable staff to move and care for this person in a safe way. In another care file we looked at we saw that a person had been risked as "Low Risk" for falls. We saw that it had been recorded on incident forms that this person had two falls within the last month. The care plan and risk assessment had not been updated to reflect this change in their care.

This is a breach of regulations 12 and 15 of The Health and Social Care Act 2008 (Regulated Activities) 2014

During our last inspection in March 2015 we looked at the staffing numbers on duty each day at Thelwall Grange. It was not disclosed to us that the catering staff only worked until 2:30pm. They made any sandwiches and left them for the evening meal. However, we were told at the visit in July 2015 that the senior care staff on late shift cooked the hot meal option. The staff cleared away the plates and washed them up leaving the kitchen clean and tidy. This meant that the afternoon shifts did not have the necessary numbers of staff to support people properly.

We saw that the current staffing levels for 27 people living at the home were one RGN, 1 senior carer and three care staff on the morning shift with 1 RGN, 1 senior carer and two care staff for the late shift. On night duty there were 1 RGN and two care staff. The acting manager told us she was interviewing staff to work in the laundry and was discussing with the provider for staff to be in the laundry on a seven day a week basis and was also requesting budget monies for more kitchen staff. The acting manager informed us on the second day of the visit that no budget was to be allocated to increase the hours of catering staff. A new staff member had been employed to work in the laundry for five days per week. We discussed how staffing levels were calculated with the new manager. She stated that the organisation had a staffing tool that determined staffing levels and they had completed this tool to send to the provider. We were informed that the home used some agency RGNs on night duty and we saw an agency RGN on duty on both days we visited. We were told that they tried to ensure the same agency staff members were used so that there was some degree of familiarity and continuity of care for people.

During day two and three of our visits toThelwall Grange no new staff had been employed to work in the kitchen after 2:30pm.

This is a breach of regulation 18 (1) (2) of The Health and Social Care Act 2008 (Regulated Activities) 2014.

We did not fully look at the medicine management in the home as this was looked at in March 2015 and found to be adequate. However, we did find some issues with medication being given covertly and this is recorded in the Effective part of the report.

On the third day of our visit we found that a calcichew tablet had been dissolved in water. The directions state that tablets should be chewed or sucked slowly not

Inadequate

Is the service safe?

dissolved in water which could affect the chemical makeup of the calcium tablets. There was no evidence that the home had checked with the pharmacy supplying the medication as to whether this was acceptable.

This is a further breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014

Inadequate

Is the service effective?

Our findings

People told us that they were happy at Thelwall Grange. Staff were able to tell us about the needs of people they looked after and how they ensured people received effective care and support. We saw staff were attentive to people's needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager and the new manager. The (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We looked at policies that were in place for staff to follow in relation to the MCA and (DoLS) and consent to care and treatment. The (MCA) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a person's best interests. These policies provided information to support staff about the procedures they should follow when a person was unable to make certain decisions for themselves.

The manager and staff understood the principals of the MCA but did not always follow these in practice. For example, they were able to explain the importance of protecting people's rights when making decisions for people who lacked mental capacity but did not always promote people's choice and respect their rights. The manager told us they had sought advice from the Deprivation of Liberty Safeguarding team at Warrington Borough Council. Senior staff had received further training with regard MCA and DoLS and were to cascade this knowledge to the care staff.

During the second day of our visit we looked at care plans and found that two people who were living with dementia had covert medication. This means that if medication is refused and it was deemed in their best interests that medicines should be "hidden" within food or drink. We found recorded in one care file that the GP of the person had given permission via fax for medications to be given covertly. The care plan stated" medications to be put in their cornflakes." A DoLS had been put in to place. However, this person was refusing night time medication and there was no indication that this should be given covertly. We did not find any capacity assessment, best interest decisions or notes of meetings or risk assessments in place. There were no records of discussion with the pharmacy to ensure that the medicines prescribed could be crushed without changing the chemical makeup of the medication. Best practice guidance states that medicines being given covertly in food and drink should be fully discussed with a multidisciplinary team and care plans in place should describe why and how they should be given.

In a second care plan it was recorded that medication was being crushed in a person's drinks. We found no evidence of capacity assessments, best interest meetings and there was no risk assessment in place as to why this person had covert medications. Capacity assessments and risk assessments should be completed before using any form of covert administration of medicines. There should be evidence of shared decision making between all appropriate parties if the person with dementia is deemed incapable of making a decision about taking the medication.

During our second visit we saw a person in their bedroom sat in a chair that was very dirty and stained with food. This person had very long dirty finger nails. We looked at the care plan and it was recorded that one staff member had to hold their hand whilst another cut their finger nails. We found that there was no risk assessment in place or any recorded details about limitations of this approach such as when staff should stop if causing the person too much distress. There was no capacity assessment completed and no best interest meetings had been held to determine if a DoLS application was needed in relation to requirements of The Mental Capacity Act for the restraint of this person during care.

We found one person who was being subjected to an unauthorised deprivation of liberty. This person was subject to a DoLS authorisation which had been approved by the local authority on the 27 July 2015 on the basis that this person should not be allowed to leave the home without supervision in the interest of their safety and well being. However, on the 12 of September we found that this person was locked into a secure area of the home (known

as the Arley Lounge) which comprised their bedroom, bathroom and a lounge. They were alone without the company of fellow residents and were unsupervised by staff. They were able to walk but were assessed as at a high risk of falls and had no means of summoning assistance. The locked area was found to present hazards to their health and safety from unprotected heated surfaces, unregulated hot water and large windows which extended below knee level and were not fitted with safety glass or safety bars. There were no risk assessments in place. A previous DoLS application had been refused by the local authority on the 14 July 2015 on the basis that it was not in this person's best interest to be confined to the locked area due to the lack of social stimulation and lack of staff supervision. The best interest assessor employed by the local authority also identified this person's confinement to the locked area of the home put them at risk of increased cognitive impairment due to the lack of social stimulation, falls resulting in potential significant injury and at potential risk of delayed emergency intervention due to the lack of supervision.

This is a breach of regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014

We found that between 22/6/15 and 4/7/15 one person had lost 8lbs in weight. They had not been weighed since and we found that people who had been assessed as having a susceptibility to losing weight had not been weighed for some time as the scales were out of order. There were no working scales in the home during our visits. The staff had not used any other preferred method of assessing when a person lost weight.

On the second day of our visit we found that there were no working scales in the home. The acting manager stated they had reassessed people living at the home to ascertain how many were at risk of losing weight. She had referred some people to the dietician however, she was unable to be accurate as to the weight loss until appropriate scales were in place.

This is a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014

We found during the first day of our visit that people living with dementia were sat in the main lounge and staff were observing them and recording their behaviour. Staff spoken with were aware that people had been subject to a DoLS but did not fully understand why they were asked to monitor people and felt that they were unable to allow them to move from the lounge area. On the second day of our visit the same people had been moved to the conservatory area of the home. Staff regularly popped in to check people's safety but staff were not always present in the lounge because they were carrying out other tasks. This meant that people could potentially be at risk because they were unable to summons help. We found that the bolt on one side of the room was not bolted shut. The area led to the outside and access to the unsecure garden area and main road. These people were subject to a DoLS due to the fact that it was unsafe for them to go out of the home unescorted.

This is a breach of regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014

We found that there were no specific design features in the home to support people who were living with dementia. The conservatory was painted white with white blinds which were old and dirty. The decoration did not help people to find their way around independently. There were no different colour schemes or signs in different corridors for people to recognise. There were no pictures to identify different rooms such as dining rooms, lounges, bathrooms and toilets. There were no objects of tactile and visual interest for the people who lived there. There was no access to a secure garden area. Staff spoken with had no clear knowledge of an overall 'vision' for dementia care in the home. People living with dementia were unable to move around the premises easily or freely.

This is a further breach of regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

We were informed by the whistle blower that the home did not always have good stocks of food. We looked in the kitchen cupboards and the freezers and found the supply of food to be satisfactory. We saw fresh fruit and vegetables and spoke with the cook who said that had plenty of food to supply good nourishing food to people who live at the home.

Requires improvement

Is the service caring?

Our findings

People spoken with said they were happy and well cared for. During the inspection staff talked about and treated people in a respectful manner. Staff knew people well; they treated them equally but as individuals. People felt staff understood their specific needs. Staff spoke affectionately about the people they cared for.

We saw a lot of interaction between staff and the people they supported and this was light hearted, warm and friendly. We saw that staff communicated well with people.

Although these were positive examples of how care was delivered, we had concerns that people's dignity was not consistently upheld and institutional practices lacked respect for people as individuals.

We looked at one person's bedroom and saw this was dirty and smelly with a stained carpet. The bedding was creased and not of a good standard and the pillows were lumpy and needed replacing. The toilet next to this bedroom had a dirty, stained floor. We visited this bedroom when we returned to the home and found it to be a little cleaner. The bed linen was still worn and the pillows had not been replaced. We saw in the toilet next to this bedroom that a used cigarette stump had been disposed of. We discussed this with the manager who immediately spoke to the person living at the home who was responsible.

Linen throughout the home was not of a good standard, was creased and needed replacement. Pillows were lumpy and looked uncomfortable, these also needed replacing.

During this visit whilst looking around the home we found that some chests of drawers and wardrobes had stickers on them stating" knickers, jumper's " etc. indicating in which drawer or cupboard staff were to place peoples clothing. This is an outdated practice and would indicate that independence and person centred care was not being fully promoted and the privacy and dignity of people was not being fully met. We saw at our second visit that no attempt to clean the stickers from the chests of drawers had been made.

At 11:30 am we went in to a bedroom and found someone in bed. The bedroom had a very bad odour. We saw that the bedside table was dirty, and the clock on the wall wasn't working. We observed that the commode was full and the bedroom did not look clean. The chart in their bedroom recorded that a drink had been given to this person at 11am but the room had not been cleaned. We observed the nurse on duty going into this person's bedroom at 12:10pm to administer medications. We checked the room 30 minutes later to see if the nurse had taken steps to empty and clean the commode and the room but the commode pan had still not been emptied and it appeared that no care staff had been in to the room to assist this person. We discussed this with the manager and took her to see the bedroom.

During the second day of our visit we observed a person living with dementia trying to get out of their chair unaided and spilling their drink. The RGN in the room was sat at the table and got up and walked out of the room past this person. They did not offer any assistance or reassurance or clean up the spilled drink. This was discussed with the manager.

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

We saw that personal information about people who lived at Thelwall Grange was stored securely which meant that they could be sure that information about them was kept confidentially.

Information was given to people before they moved into the home in the form of a service user guide. This gave people adequate information that the home would be able to meet their needs.

We observed that staff members responded to any call bells quickly or using the intercom system to let people know they were on their way and they used a dignified approach to people, for example, knocking on people's doors before entering.

Inadequate

Is the service responsive?

Our findings

At 9:45 am whilst walking around the home we looked in a person's bedroom and saw that the room chart which records how much fluid someone has taken was completed at 9:10am with 330mls given. We observed that there was full cup of tea on the table and the person was asleep. Charts that record food or fluids should not be recorded until after the person has eaten or drunk as this could provide information that is not correct. All charts to record food and fluid intake were kept in the main office. Staff then completed them at the end of the morning or afternoon. If charts are not completed contemporaneously immediately following the delivery of care there is a risk that they will not be accurate as staff have to try to remember which person had which care intervention or how much food or fluid given over a period of time

We observed one person in the lounge with very swollen ankles and feet. This person was not wearing any socks or shoes/slippers and their feet looked red and sore. We asked staff and they informed us that this person wasn't wearing socks or shoes as their feet were sore. We looked at the care plan for this person and there was no record of their feet being sore or swollen. We discussed this with the manager who said she would look in to this. When we returned to the home for a second visit we found that the care plan had not been updated to reflect the current care and support this person required.

We visited another bedroom to speak with someone who lives in Thelwall Grange. We observed they had long finger nails and looked unkempt. This person said they didn't go out of their room much and liked to stay and watch TV. They said staff were kind and the food was OK. They were unable to remember when they last had a bath or shower. The care plan said they had a history of self-neglect and needed support and encouragement with hygiene needs. There was no care plan in place for nail care. During the second day of our visit found there was still no up to date care plan for nail care.

We spoke to the relatives of someone who had been in the home for respite care. They said "The carers are great and they (carers) generally attend to their personal care but their teeth are not clean." They told us that their relative had only had two baths in the four week stay. The person had fallen out of the bath hoist and had to attend hospital for x-rays. We saw the incident form which had been completed. When looking at the care file we saw that there had been no care plans or risk assessments completed so that staff would know how to care for this person or how the best way to move this person safely including the use of the bath hoist.

Where monthly evaluations were recorded these were repetitive and uninformative about how people's needs were progressing. These included, for example, "care plan remains unchanged this month". This meant it was not possible to confirm from people's records whether their care plan was working to ensure they achieved their identified goals. The new manager informed us that training had been booked for all staff with regard to care planning.

This is a breach of regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported with individual and group interests by the activities co-ordinators and staff.

However, we were informed that there is no budget for activities. All activities provided both in and outside of the home were paid for by monies raised by staff. We were told that chair exercises provided by a visiting physiotherapist had to be stopped due to lack of funds.

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Inadequate

Is the service well-led?

Our findings

At this inspection we saw that the registered manager was not at the home every day as they managing another home in the same company whilst visiting Thelwall Grange. A new manager had been appointed three weeks prior to our visit and was being supported by the registered manager. However, by the third day of our inspection they had left the company. A member of staff from another home run by the provider told us they were acting temporarily as the manager, supported by the previous registered manager. However, this person did not have any management qualifications or experience in managing a nursing home.

Officers from Warrington Borough Council had visited the home on 27 June 2015 and had found shortfalls in staffing numbers, lack of staff in the laundry and few activities taking place. They had requested the dependency levels of all people living at the home were assessed. The first day of our visit was 23 July 2015 and this had not been completed.

Warrington Borough council had agreed an action plan with the registered provider to address the issues they had identified. The registered provider and registered manager were to meet with Warrington Borough Council to discuss the action plan following their visit and the concerns raised by them.

We found that staffing numbers and deployment of staff in the kitchen and laundry was inadequate. This must be rectified to enable care staff to fully concentrate on meeting the changing needs of people living in Thelwall Grange.

We were told by the registered manager who was visiting the home that a dependency tool was to be completed in the near future but one had not been completed as yet to fully assess the dependency of people living at the home and the numbers of skill mix and staff required to fully meet the needs of the people living at the home. On the second day of our visit we were informed that a dependency tool designed by the registered provider had been completed and given to them. This document was not shared with us.

Although there was a quality assurance programme in place issues identified at our visit had not been identified putting people living in the home at risk. We were informed that a new quality assurance manager was in post for the company and was commencing audits at the home in the near future. We raised all our concerns with the manager and registered manager on the first day of our visit in July however, issues raised had not been rectified on the second day of our visit in September.

We saw no evidence of visits or quality assurance checks undertaken by the provider in order to assess the quality of care being provided.

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

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