Bupa Care Homes (ANS) Limited

Ennerdale Nursing Centre

Inspection report

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Date of inspection visit:
14 January 2016
15 January 2016
28 January 2016

Date of publication:
31 March 2016

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**

Summary of findings

Overall summary

Ennerdale Nursing Centre is a nursing home provider based in the grounds of Aintree Hospital. At the time of our inspection the care home were providing personal care to 54 people and they had 7 empty beds. The care home has three separate units on two levels. Stananought unit is on the ground floor with 23 people requiring nursing care. Tarleton and Bridge were dementia care units located on the first floor with 16 people on Tarleton and 15 people on Bridge unit. We were informed by the manager that most people on the nursing unit on the ground level required 2 to 1 care due to their complex care needs. We were informed there were no people with challenging behaviour living in the home.

A registered manager was not in post at the time of inspection since approximately September 2015. '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 people were not safe in the care home. We were concerned people who were prescribed thickeners for their drinks were not being given the appropriate amount of thickener. As a result of this we were concerned people were at extreme risk of choking or not being able to consume the drink and at risk of dehydration.

We spoke to the managers about our concerns and sent safeguarding referrals to the local authority to ensure all the people who were prescribed thickeners in their drinks were safeguarded.

The service lacked good governance as we found systems were failing to monitor care and encourage improvement. We met with the managers of Bupa following our inspection and expressed our concerns and that improvements were required to ensure people were safe. We returned to the care home on 28 January 2016 to monitor any progress made since our inspection on 14 and 15 January 2016 and found the system of administering prescribed thickeners was still failing people. The service had demonstrated a failing to robustly reassess their systems in place in order to determine what the failings were to correct them and improve. We found the service was unable to mitigate the risks for people when we pointed them out. We were concerned that the service did not have adequately skilled staff to effectively implement a safe system and the lack of improvement was continuing to place people at risk of harm or death. Concerns raised at the inspection should have been highlighted within the service itself through quality assurance checks and audits of systems, however they were not. Therefore, the service demonstrated an inability to identify risks which were placing people at risk of harm, neglect or death through inadequate governance.

We looked at people's care plans and found that information pertaining to the individual person didn't include their background, interests or preferences and so information about the person was incomplete and not person centred. We observed people's needs were not always being considered with one person lying on their left side despite written instructions above the person's bed stating 'do not turn me onto my left

side whilst I am in bed'. People who had suffered a stroke and were unable to move themselves in bed, were reliant on staff to position them on their unaffected side. By staff not adhering to this, there was a risk of people sustaining further injury.

We couldn't ascertain when the care plans had last been reviewed or if the information had been updated in accordance with the changing health needs of people receiving care. Therefore, we could not be sure the information in the care plans was either current or accurate. This meant that staff may not have the required information to meet people's needs. We looked at positioning and weight charts and found that people were not always being turned or weighed as advised by health care professionals. One person had the incorrect positioning chart in their room which belonged to another person. This was brought to the attention of the manager and the quality assurance manager. Another person had been assessed by a health professional dated 23 October 2015 advising that the person requires a weight recording every second week. We could only see one weight recorded since then documented on 22 November 2015. This led us to believe that advice given by health care professionals was not always being followed which may then lead to people not being cared for effectively placing people at risk of harm.

There were systems in place to try to ensure that medicines were given appropriately but these systems were not being followed or being monitored. This raised concern whether the systems in place were fully effective in ensuring people requiring medicines were receiving their prescribed medication at the appropriate times or at the appropriate dosages. There were inconsistencies in the systems of administering creams on both floors within the care home. We found creams in people's bedrooms which were not labelled and therefore we couldn't be sure who the cream was for. This presented a risk of creams being contaminated if staff were applying the same cream to more than one person or of applying a cream to the wrong person. Staff were unable to locate creams for people and did not have a system in place to ensure people's prescribed creams were securely stored. In one person's room we observed a tin of prescribed thickener with the lid open which posed an infection control/contamination risk to the person who it was prescribed for.

There was not enough staff at the home to meet people's needs. We spoke with qualified and unqualified staff as part of our inspection. All the staff we spoke to demonstrated during conversation that they had a caring nature and manner. However, some staff said they were short staffed and were unable to provide the care people required all of the time.

We looked at staff recruitment files and found an induction process had been followed. Staff had not received regular supervision or appraisals. Staff told us they had received training on the Mental Capacity Act but the staff we spoke to were unable to articulate what the mental capacity act is. The care plans included a mental capacity form related to consent to care and treatment which had tick boxes for staff to tick if a person had capacity or not or whether it was variable. We found inconsistencies in the documentation we looked at regarding a person's mental capacity and we only found one person with a decision specific mental capacity assessment and evidence that the best interest's process had been followed.

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.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People who were prescribed fluid thickeners in their drinks were at risk of choking or dehydration due to incorrect fluid consistencies administered by staff.

Staff were not knowledgeable in the area of mental capacity or best interests and the documentation reflected this.

Changes to prescribed medicine dosages were not being implemented in a timely manner and prescribed creams were not labelled or stored securely.

Is the service effective?

Inadequate

The service was not always effective.

Staff were not receiving supervision or appraisals.

Staff did not have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards so we could not be sure staff were acting in people's best interests.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always able to provide consistent care due to staff being moved from one unit to another.

People were not always asked for their views or listened to.

People's privacy was respected.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans lacked information about the person's background, preferences or aspirations. Consideration was not

always given to the specific care needs of the person.

Complaints and responses were being recorded. Not everyone felt their complaints were listened and lessons were not being learnt from previous incidents.

Is the service well-led?

Inadequate

The service was not well led.

There had not been a consistent registered manager in post for over a year.

Systems in place were failing such as documenting when thickeners had been administered for people.

Ennerdale Nursing Centre

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.

This inspection took place on 14, 15 and 28 January 2016 and was unannounced.

The inspection team comprised of an adult social care inspector, an inspection manager, a pharmacy inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A follow-up visit was undertaken on 28 January 2016 to check whether the service had made changes to improve and therefore, ensure people were safe.

The Provider Information Return was returned to us 10 December 2015. This is a document providers are asked to complete and return us with details about their service. The information provided to us confirmed that there were 13 medication errors in the last year, 27 people with do not attempt to resuscitate decisions in place, 6 people at risk of malnutrition and dehydration and 27 safeguarding incidents.

We reviewed the safeguarding incident which occurred on 20 October 2015, whereby a health professional visiting a person at Ennerdale Nursing Centre intervened and prevented a staff member from giving the person a scone and un-thickened drink of tea. The person who required thickened drinks went on to develop a chest infection on 24 October 2015 and concern was raised by the health professional that the person had consumed some of the un-thickened tea.

Healthwatch were contacted prior to the inspection, as well as the local authority safeguarding team and continuing health care team who funded some of the people at Ennerdale Nursing Centre. Health care professionals were also contacted as part of the inspection.

We looked at 12 care plans and other documentation in resident's rooms such as positioning charts. We

spoke to approximately 11 people who use the service and seven people visiting on the days of the inspection. Two residents at Ennerdale were case tracked which involves looking at their records from pre-admission to when they arrived at Ennerdale.

We looked at 6 staff recruitment files and spoke with 14 staff members of varying grades and roles. A pharmacist inspector visited the service on 14 and 28 January 2016 and looked at how medicines were managed for 15 of the 54 people living in the home.

Inadequate

Is the service safe?

Our findings

We received mixed responses as to whether people felt they were safe living at the home. One person said, "I feel safe and well looked after". One person responded, "No" to the question, "Do you feel safe?" but was unable to communicate anything further. A relative told us, "We haven't been happy really as [relative] has had a few falls." Another relative told us, "We're really happy [relative] is here, we feel [relative] is safe and well looked after."

We found people were not always being kept safe. Staff were able to tell us about some of the different types of abuse they may encounter and need to be aware of, such as physical and emotional abuse and that they would report any safeguarding concerns they had to the manager. However, staff were not aware that the consequence of them not being able to provide care such as drinks/fluids or being repositioned as advised by health care professionals constituted neglect, a form of abuse.

From the documentation and speaking to staff we could not be confident staff were aware neglect can result in emotional distress, ill health, harm or death. We found some people were not administered drinks on a regular basis and were at risk of dehydration. People had been administered inappropriate thickeners and were at risk of choking or dehydration. People with pressure sores were not turned or repositioned as advised by the health professionals involved. Despite our findings staff were not raising concerns people were at risk when we spoke to them. Therefore, we cannot be confident staff were able to identify when people were at risk.

We also found that people had not received their medicines as they were prescribed. Whilst we considered that staff did not have a consistent manager to take their concerns to regarding their inability to provide adequate care for people, we would expect staff to recognise if they were unable to meet the care needs of people to such an extent that they were being neglected and report it to the local safeguarding team.

This was a breach of Regulation 13 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risk assessment documentation was difficult to find as people's care files were so large in size. For example, after written advice from a health professional in October 2015 advising that one resident should have their weight recorded every second week, there was only one weight recorded since then, in November 2015. When we visited the care home on 28 January 2016 we found a weight chart for the same person had been completed from 14 October 2015 to 24 January 2016. This contained additional information which had been entered into the records retrospectively and not in a timely manner. This raised doubt that the information being entered into the records was accurate. We witnessed a staff member retrospectively completing a fluid balance chart and the staff member told us they relied on their memory when recording the time the drink was consumed and the amount.

We were concerned the service were not undertaking safe assessments of people when receiving them back to the care home from hospital. We found one person had been received back to the care home from

hospital without the appropriate pressure sore dressings. When this was discussed with the manager it was agreed that the appropriate course of action would be to contact the General Practitioner for advice and also tissue viability nurse. From the documentation we could not see that this had been done.

The call bell system was such that the staff wore a 'pager' which was silent but vibrated when the call bell was pressed. We were informed not all staff carried a pager. We observed two people did not always have the call bell close enough to them to press in order for them to call for assistance when they felt they needed it. In the event people are unable to reach their call bell they are then unable to raise an alarm if they are unwell.

A system was in place whereby hostess's had a list of people's names with detail next to each name, stating whether the person was on a Stage 1, 2 or 3 liquid consistency. We were told there was a hostess on site for 9 hours each day but people could have a drink any time during the day or night. It could not be ascertained who administered thickeners in drinks for people outside of the hostess' daily hours. We observed that the system in place was failing. We saw one person had a jug of orange liquid in their bedroom which was not thickened to provide the person with the consistency recommended by the healthcare professionals involved in that person's care.

We found significant and serious concerns with regard to the safe and proper management of medicines for all 15 people's records we looked at. We found the provider failed to ensure that the staff who were administering medicines were skilled and competent to administer and oversee the safe management of medication.

We found that nurses and senior care staff who administered medicines failed to follow the prescribers' directions which meant people were not given their medicines safely. We saw that the medicines round took a long time to complete and people were sometimes given doses of medicines such as Paracetamol too close together which was dangerous. Antibiotics were administered at irregular intervals which meant infections may not be treated properly. When doctors prescribed new doses of existing medicines, staff did not start the new doses in a timely manner. We also saw that staff gave larger doses of medication to people than had been prescribed.

We saw that the manufacturers' directions were not always followed. Medicines, including antibiotics, which should have been given before food, were often given with food, which meant they may not work properly. We saw that nurses disregarded manufacturer's directions about how to use certain pain relieving patches which placed people's health at risk.

We saw that there was a lack of information to guide staff when administering medicines which were prescribed to be given "when required" or as a "variable dose". This meant that medicines may not be given effectively or consistently and people's health and wellbeing could be at risk.
We found that PRN protocols were in place however they lacked person centred information as to whether people were able to communicate when they required medication. We found there were a number of people whose records contained insufficient information to determine whether they could express when they were in pain or discomfort.

People who were prescribed thickeners to make sure they could have drinks without choking, did not always have their fluids thickened to the correct thickness. On the first day of our inspection we found that staff were unaware of how to thicken drinks safely. On the third day of our inspection; two weeks later; staff had received training in this area. However we found the printed guidance for staff to follow when making drinks was conflicting and confusing and was not safe. We were informed this guidance had been compiled

by the quality assurance manager.

We found that the records about the use of prescribed thickener were missing or incomplete. The records that were available were not made at the time the drinks were prepared and sometimes they were completed by a different member of staff than the staff member who had made the thickened drinks. It is important that accurate timely records are made to show that drinks have been thickened safely.

Records about medicines did not show that medicines were given safely as prescribed. We found that when the records were compared with the expected stock balances that medicines had been signed for but not given. We found records about when people should be given their 3 monthly injections were confusing and it was unclear when the next injections were due. This meant that there was a risk people may not receive their injection as prescribed.

We saw records about the application of creams were incomplete or missing. They did not show that creams had been applied as prescribed. We saw that care staff who applied creams did not make a record of the creams they applied. We found the senior carer signed the record confirming the creams had been applied in advance of the carers applying the creams. We also saw nurses sign for creams they did not apply. On the dementia suites carers had no written guidance as to where or how often to apply people's creams. They were expected to rely on their memory. We also found one person living on the dementia suite, who could not have their creams applied because there was no written information in the home for care staff to refer to.

We saw that creams were kept in people's bedrooms and bathrooms instead of being locked away securely. Staff could not locate some creams and so could not apply the creams as prescribed. We saw that people had cream in their rooms that belonged to other people living at Ennerdale, which created a risk of infection by sharing creams.

We had concerns regarding the safe storage of waste medication because it was not stored securely and arrangements for storage were not in line with the published National Institute of Clinical Excellence (NICE) guidelines. If unwanted medicines are not stored securely they may be misused.

We observed people were not being turned or repositioned at the recommended times recommended by health professionals. Staff were relying on their memory to recall when a person needed repositioning and there did not seem to be robust systems in place to ensure and check people were being repositioned at the times recommended. A health professional had recommended two hourly turns in bed for a person with a pressure sore. We observed from the person's chart in their bedroom that they had not been turned for 2.5 hours and so we pressed the call bell. A member of staff who came into the room asked what was wrong and we said we were testing the call bell system. The member of staff then suddenly recalled that the person needed to be turned. We were concerned that in the event the bell had not been pressed therefore, acting as a prompt the person would have continued to be in the same position resulting in discomfort and inadequate pressure care.
We found that one person with a grade 3 pressure sore who was unable to move themselves in bed was totally reliant on the staff to reposition them every 2 hours so as not to cause further tissue damage, pain or discomfort. The evidence we saw in the care records at 3pm confirmed the person had not been turned/repositioned every 2 hours since 11.30am that day.

This was a breach of Regulation 12 (1), (a), (b), (c), (f), (g), (h) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were a concern as staff and relatives told us that they were under staffed on the units. This was supported by our observations and discussions with staff and relatives of people who used the service. We observed one senior carer was responsible for administering medication across the two dementia units. The staff we spoke to said there was not enough staff to meet the dependency needs of the people living in the home and they had to leave some people unsupervised placing them at risk, including at risk of falls. Staff told us about situations when they were provided one to one care and supervision on the dementia unit to prevent people from wandering into other people's rooms and causing distress to others. At these times, staff were then unable to provide care and supervision to other people requiring care on the unit. We were also informed that staff were taken off their caring duties in the care home to accompany people to hospital appointments. The manager told us there was a 'twilight' staff member who comes on shift at 4pm until approximately 10pm at night who could accompany people to appointments but for all other times of the day carers were taken away from their caring duties.

This was brought to the attention of the manager and regional manager who did not seem aware there were people on the dementia units who required one to one care/supervision and they told us they would review those people and that they were continually reviewing their staffing levels. We were told that the service did not follow a dependency matrix/ tool and they assessed the number of staff required according to the care needs of the people. We were not informed of any system in place whereby staff had the opportunity to report the changing care needs and dependency levels of the people they were caring for to the management. There was not an effective system in place of recording changes in the care records. Therefore, we could not see a system in place to review and reassess staffing levels according to the changing complex care needs of people. Based on this we were concerned that the service did not have an effective or safe way of determining the number of staff required to meet the needs of the people at the care home.

One relative who spoke to us had concerns regards staffing levels, they told us "There's not enough staff, you can see that they are over busy. They don't have enough time to sit with the residents. Sometimes we've come and found [relative] wet [i.e. her pad hasn't been changed].

We could not be confident people were receiving effective care when they needed it. Some staff were concerned they were unable to meet the needs of all of the people they were responsible for. One staff member told us that some of the people on the dementia units required one to one care which resulted in staff not being able to provide the care at the time needed for other people. Staff told us that at other times they were unable to supervise people who required constant supervision and those people were at risk of harming themselves or others. A relative told us, "Staff are over stretched, there are some residents who need supervision all of the time." The relative described a distressing incident whereby the person receiving care became distressed when another service user lay down on their bed as they were confused. The relative told us the person who entered the room by mistake "Can become aggravated" and was not being supervised at the time. They told us this resulted in their relative feeling upset and distressed. Staff told us of another resident on the dementia unit who fell frequently and staff were unable to provide one to one supervision at all times to mitigate the risk of falls. We could see from the records that the person had been having several falls over a period of months. This was brought to the attention of the manager who agreed to review the care needs of the people who were requiring one to one supervision on the dementia unit.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked in 6 recruitment files and found they all included an application form, induction, references and Disclosure and Barring confirmation to ensure people being recruited did not have any previous convictions

which may place people at risk.

We saw that fire alarms and equipment were tested on a regular basis and fire drills had also taken place. The manager provided us with individual fire evacuation plans. We looked at certificates that showed fire equipment had been passed as fit for purpose by an external company. In addition to this the provider had certificates to show compliance where gas and electrical safety was concerned. We looked at how equipment was managed in the home. We saw certificates that showed lifting equipment such as hoists had been examined by an external organisation within the required timeframe. The service employed a maintenance person who had also carried out their own regular checks in relation to this as well as other areas such as legionella and other aspects of health and safety.

Inadequate

Is the service effective?

Our findings

People's views about staff abilities, skills and knowledge were mixed.

One person told us, "Staff are smashing, really good." Another person told us, "The staff are very nice, but it's just a job to them. It's up to you to tell them what's what. They don't come and check on you." A relative said, "When we ask how she's been, we often get the response, 'I don't know I've just come on." One person told us, "You see a lot of faces because the staff move around from one unit to another."

We were informed by staff and the manager that staff had not been receiving regular supervision for some time but this was something the manager wished to reintroduce into the care home. Supervision is often useful for both staff and management to communicate any concerns and highlight any training requirements. It is also time for staff to discuss any concerns they may have in relation to people they care for. In the absence of regular supervision it is more difficult for staff to raise any concerns they have and for management to identify areas which require improvement. Staff we spoke to also told us they had not received annual appraisals but had received a staff induction.

Staff we spoke to told us they received training to be able to undertake their role and responsibilities. We were informed by the manager that they kept a list of training requirements for staff. We asked for information to inform us about staff training and we were provided with a list of training which staff were booked onto in the future. Staff told us they had received training in safeguarding and the mental capacity training but were unable to articulate what the Mental Capacity Act is. The care record documentation reflected that there was a lack of understanding about how staff should be implementing decision specific mental capacity assessments as part of their practice.

We found staff were not knowledgeable in the administration of prescribed thickeners to ensure people were consuming liquid at a consistency that did not result in harm. Both hostesses' we spoke with did not have any record of training being undertaken in administering prescribed thickeners. One hostess told us they had received some training before Christmas but welcomed more training as they didn't understand parts of the training given. Another nurse we spoke to said, "The hostess didn't really know how to make the drinks" and, "She was doing her best." One hostess was observed to be prompted by a staff member; "Don't forget it's two scoops." Another qualified staff member was observed to not be competent in assessing the appropriate consistency of the various stages of liquid consistency for people on different stage consistencies. . The risk of people receiving an inappropriate and unsafe amount of thickener in their drinks was placing people at risk of harm including chest infection and aspiration pneumonia. Aspiration pneumonia is inflammation of your lungs caused by a foreign substance such as vomit or liquid entering the lungs. We observed prescribed thickener was not always stored and locked away securely.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we looked in people's care plans the documentation regarding the person's mental capacity was

mostly inconsistent and not decision specific. 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.

We found evidence of the Mental Capacity Act being considered in relation to whether people had the capacity to consent to their care. The assessment form titled 'Choices Over Decisions Over Care', which comprised of a tick box question and answer form was being completed and could be seen in the records. We could determine that staff demonstrated a lack of understanding of the Mental Capacity Act from the inconsistencies about the person's mental capacity documented. For example, it was documented in one person's care records – "X can make their own decisions over care but may need encouragement to make the right decision regarding care needs in their own best interests".

We did see evidence of Deprivation of Liberty Safeguards (DOLS) assessments related to capacity to consent to care but we could only find evidence of one decision specific mental capacity assessment and a best interest process being followed in relation to a specific decision. Best interests decisions are any decision made or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DOLS).
We found evidence of a bed rail risk assessment in one person's care plan but no evidence of a mental capacity assessment or DOLS application for the use of bed rails. We therefore, could not be confident staff had the knowledge and skills to always follow the Mental Capacity Act and Deprivation of Liberty Safeguards to act lawfully and in people's best interests.

We were contacted by a relative who informed us that they requested their relative, who resided at the care home, be transferred to another care home due to their on- going concerns with the care being provided. The relative was informed by the local authority that a staff member at the care home informed the local authority that the person receiving care was able to make their own choices and decisions about whether they wished to move from the care home. The relative told us the person receiving care was very confused and was unable to recognise relatives when they visited them in the care home due to the severity of the effects of dementia. This demonstrated that the staff member had no knowledge of the person's mental state to be able to effectively assess the person's mental capacity in relation to specific decisions.

An urgent DOLS application form had been completed, signed and dated 29 September 2015 for one person, but there was no evidence seen of a mental capacity assessment or best interest assessment in relation to the decisions that needed to be made.

During the inspection we looked in a number of care plans to look for evidence of Do Not Attempt to Resuscitate Forms (DNACPR) completed for people. The service were failing to implementing an effective and safe system of assessing service user's Mental Capacity to make the decision of being resuscitated. This was placing people at risk of not being resuscitated either against their will or without lawfully following the legislation according to the Mental Capacity Act 2005.

The care records for one person stated that the DNACPR had been signed by a member of the medical profession and a family member on 26 October 2015. We noted however, from the care plan that the person was deemed to have capacity to consent to care. We brought it to the attention of the manager that we

could not see any evidence that the mental capacity and best interest's process had been followed in relation to DNACPR. The manager agreed this was not good practice and told us we were likely to see that others will have been completed in the same way throughout the home.

This was a breach of Regulation 11 (1), (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke to told us they enjoyed the food and said they had enough choice of foods. People also said that they had drinks when they wished. One person told us, "The food is really good, it's smashing." We observed how lunch was provided for people on our inspection. On Stananought unit there were 4 tables and a total of 6 diners. At one of the tables a resident was being helped to eat by his visiting relative. Another diner was sat at the table in her wheelchair. Although there was some interaction between staff and diners, lunchtime did not appear to be a social event. On Tarleton lunch time appeared to be more of a social event with conversation between diners as well as with staff.

We looked at documentation such as fluid balance charts and food charts and found some people who required fluids and dietary intake monitoring were without the appropriate documentation. This placed people at risk of their health deteriorating over time without staff being aware due to a lack of accurate recording and reporting.

We could not be confident people were always receiving an appropriate amount of food or fluids as the records were being completed retrospectively by staff. We observed this during our inspection and found examples where staff were completing records retrospectively. For example, one staff member entered into the records that they provided one person a specific amount of fluids at 11.30am on 14 January 2016 two hours after the event. When asked if the staff member had a system of recording the times/amounts given to people the manager was unaware of a system in place and the staff member said they relied on their memory.

One resident was admitted to hospital on 28 January 2016 due to dehydration. When we looked at the person's fluid charts we found there were significant periods of time when records reflected that the person had not been offered a drink. When we looked further in the records we found that the same person had been admitted to hospital in December 2015 with a chest infection and dehydration. There were a number of people at the care home who were frail and in need of nursing care but we could not be confident that the service was able to administer adequate amounts of fluids for people in order to maintain their health and well-being.

We were told by one relative that staff offer a drink and if it's declined at that time by the person, staff then do not have the time to keep trying and encourage the person to have a drink when they are more lucid or aware. We were told that without family members visiting to encourage regular drinks they would be concerned about their relative's hydration levels.

Another relative told us they were informed over the telephone by a staff member that the person receiving care had a serious water infection. When the relative visited the care home they were then told by a different staff member that this was not true and the person had become dehydrated.

This was a breach of Regulation 14 (1), (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had good links to GP services, community matron and other health care professionals such as

dieticians and speech and language therapists. This helped to ensure people were supported by external health care professionals to maintain their health and wellbeing.

The dementia units within home were working towards becoming dementia friendly although improvements were still required. There was pictorial signage on the bathroom, lounge and toilet doors that were visible which made them easily identifiable. We saw that some of the doors and surrounding walls to people's bedrooms were personalised to support orientation. However, this was not the case with regards all of the bedrooms on the dementia units. There were very few items about for people to touch, pick up and encourage interest or discussion for people living with dementia. The manager told us that this was work in progress and they were in the process of making improvements to make the home more dementia friendly.

Requires Improvement

Is the service caring?

Our findings

We heard mixed views about the care people received.

One relative told us, "The staff are very kind, very good. They talk to me as a person, sometimes if they've time they'll stop and have a chat. They knock on the door before they come in and talk to you by name. They're nice to me and my visitors. I'm happy, very satisfied."

One relative said, "Some individual members of staff are really nice and caring, but because staff leave or are moved around from unit to unit or the service user is moved from one room to another or one unit to another, staff don't get used to them, or them to staff."

We were informed at the beginning of the inspection that the laundry system had been improved with a labelling system when clothes were brought into the care home. We however, observed unlabelled clothing which had been placed on top of laundry trolleys in one bathroom. This showed that the new system was not effective. One relative told us they had brought in replacement garments recently due to clothing going missing.

We found that staff were not always able to clearly explain what people's care requirements were which informed us staff were not always knowledgeable about the people they were caring for. One relative told us that they were concerned the staff did not know crucial information about the person receiving care. For instance, when their relative experienced a change in their health, the relative asked staff whether it was related to their existing condition; however the staff were not aware of the condition... Another relative told us they had concerns staff were not knowledgeable about individual people receiving care because when they asked staff how the person was, they are often told, "I don't know I've just come on."

We observed that staff were pleasant in their manner with people. However, we were concerned that for people who were unable to communicate their needs and were totally reliant on staff members to consistently follow the care recommendations in their care records, they were not always cared for adequately. People who were unwell, frail or receiving end of life care and whose state of consciousness was intermittent were totally reliant on the care staff to always deliver care in a considerate, compassionate way. People suffering with dementia were also reliant on staff to ensure they were being cared for effectively. We found evidence staff were not always delivering care in a compassionate way as they were not following the recommendations made by health care professionals set out in the care records and did not seem concerned by this. This did not give us confidence that people were being cared for to prevent pain and discomfort.

Visitors and relatives were welcomed and we observed visitors/relatives visiting during the course of the inspection.

Some relatives reported they did not always receive the information they requested from staff. One relative said that they felt, "Fobbed off", when they asked why their relative had fallen.

We were provided with a customer feedback sheet for people to complete if they wished to raise any concerns, complaints, compliments or suggestions but we could not see this actively being used in the care home.

Inadequate

Is the service responsive?

Our findings

At this latest unannounced inspection, we were informed that the service had been recruiting for a manager and they had a strong candidate whom they were considering for the position. We were informed that the service was in the process of decorating and furbishing a new 'snug' room for people with dementia on the Bridge Unit which had begun, following input from the Admiral Nurse for Dementia Care. We were also told that a new laundry system had been implemented within the care home which involved people's clothing being labelled to ensure they did not go missing. On the first day of the inspection we observed the activities coordinator assisting people to access the on-site hairdressers which had recently been set up for people at the care home to use.

The care plans we looked at on the first day of the inspection were 'chaotic' and it was difficult to locate specific information. The pre-admission paperwork had been completed and the files identified care requirement sections such as, safety, moving around, senses and communication, choices and decisions over care. What was not clear was when these and the other sections in the file were being updated according to any changes to people's health, well- being or any risks. We therefore, could not be sure people's care plans and risk assessments were being fully updated following a hospital admission and return to the care home.

There were other details within the care file of the same person receiving care that were difficult to find as initially a body map following discharge from hospital of the resident could not be seen in the file. The file was looked at together with both the staff member and the specialist advisor and the staff member explained that photographs were taken of a pressure area before the resident went into hospital and also after re-admission back to the home. The photographs were seen to be appropriate prior to admission but when the resident had returned from the hospital the photographs taken did not appear to be dated and there was no body map. Later in the day the body map of the person who had been discharged from hospital back into the care home was seen in the records and the detail on the body map did appear to match the detail on the photographs.

A person centred approach to the delivery of care was not clearly demonstrated. Within the care plans we looked at, there was no evidence of specific preferences that people may have for staff to then be able to understand the person's personality and personal background. It was not evident that people had been asked about themselves as part of the process of writing the care plans. We were therefore concerned people's wishes and preferences were not being followed.

This was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities coordinator at the care home. One resident said, "The activities coordinator is very good. We have bingo, music, different things. I enjoy the activities and don't feel bored. I've never had to complain. I'd go to the office I suppose [to complain], but I've no need to. If it's nice, the family will take me out in the wheelchair. The gardens are lovely in summer. You can go out when you want. It's nice to get the

fresh air, I like it."

We did not see any activities going on in the care home. We were informed that the activity co-ordinator provided entertainment such as bingo, knitting, sewing, baking and dancing. There was an activities notice board to inform residents and family of daily activities. Planning included weekly events and the activity co-ordinator recorded details of all residents who took part in activities. The activity co-ordinator visited other people separately if they have not attended, to see what they would like to do. This did not include those who were unwell. There was a plan to commence a residents committee on the last Thursday of each month.

We saw a complaints procedure was in place and people, including relatives, we spoke with said they would speak to the manager if they needed to complain. However, we saw that the systems to manage complaints was not effective and did not appropriately deal with complaints that were made. One complaint we looked at was from a relative who raised serious on-going concerns in relation to the person residing at the care home not receiving supervision to have medication or fluids. The relative was the second family member to raise the concerns as they did not receive a response when the concerns were first made four to five weeks earlier. The relative had visited the person at the home and observed there were 12 tablets in the person's room untaken and cups of drinks left in the room. Other concerns included a high turnover of staff and relatives having to repeat information to staff and nothing being done. We saw a response from the manager in the complaints file informing the relative an investigation had taken place but the response failed to address why the person had not been supervised to take medication in the first instance. The response also failed to address why the person had not had their drinks to maintain hydration levels.

This was a breach of Regulation 16 (1), (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was no registered manager and a temporary manager was in post at the time of our inspection from November 2015 onwards.

We asked staff and residents for their views regarding how the care home was managed. Staff we spoke with told us they were pleased to have a new manager in place. One staff member told us that the offsite managers visited but did not connect with the staff when they walked around so they did not get to know the views of the staff. We were concerned about the culture of staff not being able to communicate with management. The lack of consistent manager had impacted on the service, people receiving the service and their relatives.

A relative told us, "Unfortunately there has been quite a few changes of management, and the current one is only an acting Manager. However, I've managed to build a relationship with each of them. I've no qualms about approaching them." One person said, "The manager always has a chat with me".

A relative told us "We've not had any meetings with the management or filled in any questionnaires and until this incident before Christmas not met any of the management previously." Another relative told us, "[Relative] was quite happy in their previous room and they moved [Relative] upstairs into a smaller room. They had no choice. The management told us that if she didn't move she would have to go to another home. We've tried complaining but just feel ignored. For whatever reason, managers don't seem to stay long, so there's no continuity."

We were informed by the manager that the service held a relatives meeting once every 3 months but we did not see evidence of this.

There was no effective leadership of the service and there was be a culture of not being aware how serious it was for people if they received poor care placing them at risk of harm or death. We observed systems in place which were failing and there were inconsistencies in the way care was being delivered throughout the care home, which we attributed to stem from poor governance. Management were unaware of the staffing issues to meet the needs of the people in the care home and did not have a system in place to assess staffing levels according to the changing care needs of people. We could not see how management were ensuring they were listening to staff and the views of staff being acted upon. There was some evidence that the manager had begun to review procedures in place but we did not see any lessons learnt or improvements being made to the overall delivery of care. In addition to this, the provider had failed to pick up on all of the concerns identified by us on this inspection.

A staff member told us about their concerns that the systems of documenting information were not overseen other than by the nurses who were providing the care. The staff member told us of an occasion when they were asked by a health professional for care records pertaining to a person with complex health care needs. They said they were embarrassed to be in a position to explain to the health professional that the documents were missing from the care plan and they believed they did not exist.

We asked the manager if documentation is kept anywhere else in the care home in order to ensure we had seen all the documentation for people. We were informed we had received all the documentation we requested. We were informed of a system of checking care plans on a rota basis but we could not see evidence of these checks in the care records. A lack of oversight of the documentation in place was evident, demonstrating a lack of governance.

We were provided with a copy of the service's policy (Bupa UK Care Services, safeguarding vulnerable adults – policy and procedure) dated June 2015, which detailed an exhaustive list of the indicators of abuse and types of abuse staff should report. Some of those areas included; non administration of medication, depriving the resident of food and drink, threatening to withdraw support/services, malnutrition, development of pressure ulcers, being left in wet clothing and dehydration. We found the service was failing to follow their policy as they were not able to demonstrate that they recognised the types of abuse which were reflected in their own delivery of care.

The service had demonstrated a lack of ability to learn from previous safeguarding incidents. We were aware of a previous serious incident in October 2015 whereby a person was given some un-thickened tea and consumed some of it before a health professional intervened to stop further consumption. We were concerned that despite this and the person being admitted with aspiration pneumonia some weeks later, the service had not robustly checked their system of administering thickeners in drinks, so failing to mitigate the risk of this reoccurring. We told the service on our inspection that they were failing in this area and action was needed to improve the system of administering thickeners. When we visited the care home again on 28 January 2016 we found unsafe practices were continuing. Based on this pattern of failings we are not confident that the service had the necessary skilled staff to be able to improve the systems in place at the care home. In view of the seriousness of the impact of these failings on people such as death from choking, aspiration pneumonia or ill-health/death from dehydration we would have expected the service to have mitigated the risks which were evident from the initial safeguarding incident in October 2015. The service had failed to review their systems to ensure people received safe and effective care and treatment.

This was a breach of Regulation 17 (1), (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.