Moorshield Limited

Finch Manor Nursing Home

Inspection report

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22 May 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an inspection of Finch Manor Nursing Home on 17, 19 and 22 May 2017. The first two days of the inspection were unannounced. Finch Manor Nursing Home is registered to provide accommodation for up to 89 adults who require support with their mental and physical health. At the time of the inspection 81 people lived at the home.

The home had a registered manager in post. 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.

At our last inspection of the service in November 2016, we identified breaches with regards to Regulation 12 and Regulation 18 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014. This breaches related to medication management and safe staffing levels. At this inspection we found no improvements had been made. We found breaches of Regulations 12 and 18 again in addition to breaches of Regulations 9, 10, 11, 14, 16, 17, and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were assessed by CQC as serious as they placed people who lived at the home at risk harm.

We looked at the care files belonging to nine people. We found their needs and risks were not properly assessed, planned for or managed. There was insufficient information on how to meet people's needs and to provide their care in the way they preferred. Risk assessments were inadequate and did not provide staff with sufficient guidance on how to manage people's risks and keep people safe. People's nursing needs were not adequately described or monitored by nursing staff and people's day to day care did not show they received the care and support they needed from nursing and care staff.

People's capacity was not properly assessed in accordance with Mental Capacity Act 2005 and their care files lacked evidence of their involvement in the assessment process. It was unclear how these assessments were undertaken as there were no best interest records on file and no evidence that any least restrictive options were explored. Some people had a deprivation of liberty safeguard (DoLS) in place but the documentation in respect of this was poor and did not show that proper legal process had been followed.

Medicines were not safely managed, administered or disposed of. Records showed that people frequently missed their prescribed medication and sometimes had a delay in receiving the medication they needed from the pharmacy. This placed people's health at significant risk and meant that people may unnecessarily suffer the symptoms their medication was prescribed to relieve. We found that staff lacked sufficient knowledge of the medications and supplements people needed and we observed medication being administered in an unsafe way. The registered manager and home manager acknowledged that they were aware that management of medication was unsafe but had taken no effective action to address this.

People's nutritional needs were not always met in accordance with medical advice. People's nutritional care plans lacked information about people's special dietary requirements and staff lacked sufficient knowledge of people's dietary needs in order to mitigate the risk of malnutrition. During our visit, the majority of feedback from the people and relatives we spoke with about the food on offer was positive but when we checked the provider's complaints records, we saw that several complaints about the quality and quantity of the food had been made to the registered manager over the last 12 months.

Staffing levels were insufficient to meet people's needs and the staff employed were not always recruited in safe way. Staff were not supported appropriately in their job role or supervised effectively in their day to day jobs. Nursing staff had also not completed the provider's mandatory training programme which meant that there was a risk that their skills and knowledge was not up to date. During our discussions with staff, the registered manager and the home manager they failed to demonstrate that they had sufficient knowledge of people's needs and risks in order to provide safe, effective and responsive care.

The provider's fire and emergency procedures required improvement to ensure people could be safely evacuated, parts of the premises and its equipment were not safe or suitable for purpose and there was a lack of suitable systems in place to mitigate the risk of Legionella.

Care staff were observed to be kind and patient in their interactions with people but the majority of their time was spent on completing tasks. In some units care staff had minimal social interaction with people who lived there. Nursing staff, the registered manager and the home manager were not a visible presence in the home and it was unclear what role nursing staff played in the delivery of people's care.

There was a complaints policy in place but people's complaints were not always effectively addressed. This was because records showed that the same concerns came up repeatedly in the delivery of people's care.

There were no effective systems or processes in place to ensure that the service provided was safe, effective, caring, responsive or well led. Audits were undertaken but they were ineffective in identifying the issues found during the inspection, most of which were of a serious nature. Where concerns with the delivery of care had been identified, appropriate action had not always been taken by either the registered manager or home manager to ensure they were addressed to protect people from harm. The provider did not play an active role in the service and had not undertaken any effective checks on the service to ensure it was safe and satisfactory.

After our visit, we asked the registered manager and provider for an urgent action plan on how they were going to ensure immediate and significant improvements were made. An improvement action plan was submitted and is in progress. We also met with the registered manager and the provider alongside the local authority and the NHS clinical commissioning group's medicines team. Both the local authority and the clinical commissioning group's medicines team are now also supporting the service to make the required improvements in order to protect people from risk.

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 from the providers 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.

Medication arrangements were unsafe. People regularly missed their medication and staff were not competent in administering medications in a safe way.

People's individual risks in the planning and delivery of care were not properly assessed or managed.

Inappropriate moving and handling techniques were used and people did not always receive the care they needed to keep them safe and well.

Staff were not always recruited safely and staffing levels were insufficient to meet people needs.

People told us they felt safe at the home.

Is the service effective?

Inadequate

The service was not effective.

The provider did not have suitable arrangements in place to ensure people's legal consent to their care was properly obtained in accordance with the Mental Capacity Act 2005.

Staff received insufficient support to do their job role effectively and the majority of nursing staff had not attended the provider's mandatory training.

Systems in place to monitor and manage people's nutrition and hydration risks were not robust enough to ensure people's needs were met.

Is the service caring?

Inadequate

The service was not caring.

Staff were kind and patient when people needed support but some staff had little time to meaningfully interact with the people they cared for.

Staff did not always ensure that people received the support they needed. People were not always treated with dignity and respect.

People's personal information was not kept confidential or disposed of securely in line with the Data Protection Act 1998.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans lacked information of people's needs and preferences to enable person centred care to be delivered.

People who lived at the home did not receive individualised care that met their needs. Staff lacked knowledge about their needs in order to be responsive.

Opinions about activities were mixed. There was little evidence that the activities provided were consistent and meaningful to people or reflected their preferences.

The complaint system in place was ineffective as it did not ensure that people's complaints were addressed sufficiently.

Is the service well-led?

Inadequate

The service was not well led.

There were no effective systems or processes in the home to ensure that the service was safe, effective, caring, responsive or well led.

Where concerns with the service had been identified, there was little evidence to show that appropriate action had been taken by the registered manager or the home manager to protect people from harm.

The registered manager and home manager lacked sufficient knowledge of people's needs and the care they required.

The provider was not an active role model and did not effectively check that the quality and safety of the service was satisfactory.

Finch Manor 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.

This inspection took place on 17, 19 and 22 May 2017. The first two days of the inspection were unannounced. This inspection was carried out by three adult social care (ASC) inspectors and a specialist medicines inspector.

We carried out this inspection because we had received a number of concerns and safeguarding referrals in relation to this service and the care people received. Prior to our inspection, we reviewed these concerns to help us plan the inspection effectively. We also looked at any information sent to us by the registered manager and provider and we liaised with the Local Authority.

We spoke with five people who lived at the home, two relatives, two visiting social workers and a visiting member of the clergy. We also spoke with the registered manager, the home manager, the finance director, five care co-ordinators, four care assistants, two nurses and a member of the catering team.

We looked at nine people's care records, seven staff recruitment files, records relating to staff training and supervision, medication administration records and other records relating to the management of the service.

We observed people and staff throughout the inspection and saw how people were being cared for.

Inadequate

Is the service safe?

Our findings

At our last inspection we had concerns with regards to Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to medication management and staffing levels. At this inspection we found that no appropriate action had been taken to address our concerns. In addition, during this visit, we identified serious concerns with the care and treatment people received. We found the service unsafe and after our visit, we referred our concerns to the safeguarding team at the local authority to ensure an investigation into people's care was undertaken without delay.

An electronic system for recording the administration of medication had been introduced into the home since our last visit in November 2016. We found that the registered manager and home manager did not fully understand how the system worked. They told us that staff were not using the system correctly and acknowledged they were unable to check that medicines were given safely. Despite knowing this, they had taken no adequate action to address it. They were unable to account for the medications in the home when asked and on the day of our visit we found serious discrepancies with the amount of medication in the home and what had been recorded as administered to people. For example, there were 76 doses of one person's medication missing and unaccounted for. The registered manager and home manager had no idea that this medication was missing or what had happened to it.

Medication was administered to people who lived at the home by care co-ordinators. We saw that the care co-ordinator was similar to a senior carer role. Care co-ordinators were not qualified nurses. In a nursing home it is normal practice for nurses to give people who require nursing care their medication. The task of administering medication can be delegated to a none nurse in certain circumstances but there are very strict guidelines laid down by the professional body for nurses (the nursing and midwifery council) to ensure that staff who are delegated this task are competent to do so. We found that there was no robust system in place to determine this and during our visit we had serious concerns with regards to the competency of the care co-ordinators who were responsible for administering people's medication.

Some people required thickening agents to be added to their drink to ensure they were able to swallow safely when drinking. Thickening agents are used to thicken the consistency of fluids to reduce the risk of a person choking. The amount of thickening agent to be added is prescribed by a medical professional based on the person's individual risks. We found that some staff at the home lacked sufficient information and knowledge on how to use these thickening agents safely.

For example, one person in receipt of nursing care required thickening agents to be added. When asked, nursing staff did not know how thick this person's drinks needed to be in order to protect them from potential harm. The nurses told us they did not make people's drinks so they did not know how thick to make them. Nursing staff have a professional duty to ensure they have sufficient information to care for people safely. We asked the care co-ordinator and staff on duty how thick the person's drink should be made. They told us different information to what was recorded on a printed list. This meant there was a risk that the person's drinks were not thickened to the required consistency to prevent them from choking.

Some medicines were not stored safely. We saw two large bins full to the brim with waste medication which were not locked away or disposed of safely in line with current guidance. This meant that they could be easily accessed and misused. Records relating to this medication did not match the quantity of medication in the waste bin and we found that some people's medication which they still needed had been placed in the waste bin to be disposed of.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not stored, administered, managed or disposed of safely. This placed people at significant risk of harm.

We asked people if they felt safe and they told us they did. Relatives told us they felt people were safe. During our visit, we did not find that this was always the case.

We looked at nine people's care files. Some, but not all of the risks in relation to their care were assessed. Risk assessments were contradictory, lacked sufficient detail about people's individual needs and contained little guidance for staff to follow in order to keep people safe. Where professional advice had been given we found that this advice was not always followed to ensure their risks were safely managed and in some cases staff did not even know what this advice was.

For example, one person was at risk of malnutrition and required a specialised diet to prevent them from becoming malnourished. A dietician had advised staff to ensure the person received a fortified, high protein diet. They had prescribed a dietary supplement to be given to the the person two to three times a day to boost their dietary intake. The person's risk management plan was not updated with this advice and we found that person had not received any of their prescribed supplements as none were available in the home. None of the staff including the registered manager had checked to find out why they had not arrived. We found another person with 180 dietary supplements in their wardrobe. Some of these supplements had been dispensed by the pharmacy in March 2017 but had still not been given to the person.

One person care file indicated that a physiotherapist had advised staff to use a full body hoist at all times to support their mobility. On the day of the inspection, we saw that this advice was not followed. We asked the registered manager about this. They told us they were unaware of this advice and acknowledged that they did not know if the way in which this person's mobility was being supported by staff was safe. Further incidences of poor moving and handling techniques were also observed during our visit. These techniques placed people and staff at risk of physical injury.

We checked the nursing care provided to people in relation to their pressure sores. We found that some people's wounds were not properly assessed or cared for. Wound management is a basic aspect of good nursing care but we found little evidence that people's wounds were managed appropriately. We found that people who required clinical observations to be taken in respect of their physical health had little evidence in their care files to demonstrate that these observations were undertaken and their health monitored. For instance one person had an irregular heartbeat. Staff were advised by a medical professional to monitor this but there was no evidence that any clinical observations had been undertaken. This meant we found little evidence that people received the clinical care they needed to keep them safe and well.

We spoke with the registered manager directly about our concerns. It was clear from our discussions, that the registered manager lacked sufficient knowledge of people's needs and the care they required. For example, they lacked knowledge of which people had pressure sores, those people with a catheter in place and those people in receipt of end of life care. It was unclear therefore how the registered manager was able to ensure people's risks were managed and their needs met, when they themselves were not clear what

these were.

We saw that the home's gas, electric, fire alarm and moving and handling equipment had been inspected and were safe to use. During our visit however, we found that parts of the home were malodorous and required repair. One of the shower rooms had a whole in the wall which meant pipes were exposed. One person's laminate flooring was cracked and loose and numerous bedrooms contained trailing wires, all of which posed a serious trip hazard. Some people's chest of drawers had no handles and one person's chest of drawers was completely broken and had not been fixed. Latex gloves used in the delivery of care were found discarded outside of the home on the garden verges and we saw that there were numerous cigarette butts around the home to indicate that staff and service users were not smoking in designated smoking areas.

We saw that a fire exit at the rear of the home was unsecure. Service users and visitors to the home were seen to enter and exit through this door into the car park without the necessary security checks. It also meant that people who lived at the home could exit the building without staff knowledge. We spoke with the manager about this and asked them to address it immediately. We saw that the unsecure fire door had been raised previously by the Local Authority with the registered manager and that the registered manager had provided assurances to the Local Authority that it had been addressed. Clearly it had not.

We checked the fire evacuation procedure and found it be unsafe. There was no evidence that any recent fire drills had been undertaken to ensure staff knew what to do should the fire alarm sound. A nurse we spoke with said they could not remember when they had last participated in a fire drill. This did not demonstrate that there were adequate arrangements in place to ensure people were protected from harm during a fire or other emergency situation.

We looked at people's personal emergency evacuation plans (PEEPS) in two of the units. These plans advise staff and emergency services how best to support people during an emergency. We found that the PEEP information contained in the nurse's office in one of the units did not contain evacuation information for three people who lived on this unit. The registered manager told there was an evacuation grab bag stored in the stairwell of the home which contained PEEP information in relation to everyone who lived at the home and that this would be the information used in the event of a fire.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

We looked at how the provider monitored the risk of Legionella in the home's water system and found there were no effective systems in place to do so. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety Act 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. The provider failed in this duty of care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have systems and procedures in place to assess, monitor and prevent the spread of infection

Staffing levels were unsafe. Two nurses were on duty during the day to care for 81 people, 56 of whom required nursing care. At night the number of nurses on duty reduced to one. Records of people's care showed little evidence that people received the clinical support they required and the staff members we

spoke with told us that there were not enough nurses on duty to be able to support people appropriately. One staff member said that people in their unit "Rarely saw a nurse". During our visit we observed this to be the case. Nursing staff were not a visible presence on any of the five units we spent time in, even when people were unwell.

There were approximately 17 care staff on duty during the day which reduced to 12 after 10pm at night. This amount of care staff did not seem unreasonable based on the number of people who lived at the home. When we asked staff members however how many people required two carers to assist them at any one time it became clear that the majority of people required this level of support. This would have impacted on the ability of staff to meet people's needs. The deployment of staff during the day across all five units of the home was poor and not well organised. For example, in one of the units, there was no active supervision of staff tasks and this created a disorganised feel to the unit especially at mealtimes during all three days of the inspection.

During our visit we found evidence to indicate that people who lived at the home did not receive the care they needed. We asked the registered manager how they had ensured staffing levels were safe and sufficient to meet people's needs. They were unable to tell us. They acknowledged they undertook no formal analysis of people's dependency needs when determining how many staff should be on duty. When we asked how many people were of medium dependency, they told us, "I couldn't tell you". This meant there were no systems in place to ensure that the number of staff on duty was sufficient to meet people's needs. Despite this they were still admitting new people to the home.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were insufficient staff on duty to ensure people received safe and appropriate care.

We looked at how staff were employed and found that safe recruitment practices were not always followed. Staff records showed that some people had been recruited with inappropriate references and staff were often promoted to more senior roles without any evidence of their suitability and competency to do so.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment processes were not robust and did not ensure that fit and proper persons were employed to work at the home.

Inadequate

Is the service effective?

Our findings

One person we spoke with told us that the food was "Excellent. We get a choice. I get enough to eat and drink". Another person told us that there were happy with the food and could have something to eat and drink when they wanted. A third person said "It's not bad, it's improved a lot recently".

Most relatives thought their loved one got enough to eat and drink. One relative showed us the sandwich given to their loved one at lunchtime. We saw that it was a ham sandwich with hardly any ham on it. The relative told us it "Drives me mad". They asked for another sandwich to be provided with more filling in it. This request was facilitated and when the cook brought the second sandwich we heard them apologise to the person and their relative. When we checked the provider's complaint records we saw that numerous complaints about the quality and quantity of the food provided to people had been received by the registered manager over the last 12 months.

We saw that people had a choice to either eat their meals in their bedrooms or the lounge/dining room. The home operated on set mealtimes during the day and had a four week rolling menu from which people had options to choose from. Staff told us they asked people what menu option they would like for lunch and tea each morning.

We checked people's nutritional information and saw that it was mostly generic. This meant it gave general advice about everyone's nutritional care as opposed to specific advice about each person's dietary needs. Where additional information had been added about people's needs, it was not always clear.

For example, two people's care files indicated they required a pureed diet (a texture modified diet) as they were at very high risk of choking. There are standard descriptors developed by the National Patient Safety Agency to be used by all health professionals to describe the different textures people's meals can be. For example, a thin texture or thick texture pureed diet. Despite this, there was no information on the texture or consistency of the diet required in either person's care plan. This meant there was a risk that staff would not know what texture of diet was safe to give them. We observed a care co-ordinator hand blending one person's pudding at tea time. We asked the member of staff what consistency they were blending the person's pudding to. They did not know. This meant that there was a risk the diet provided was not safe or suitable for the person to eat. It also showed that staff did not know what type of diet people needed in respect of their nutritional health and safety.

We visited the kitchen and spoke to the cook on duty that day. We asked them about people's special dietary requirements. They did not know who was on a special diet and had no written information on people's dietary needs in order to ensure suitable meals were prepared.

We saw that one person's diet needed to be monitored to ensure their food and drink intake was sufficient to maintain their well-being. There was no evidence that any monitoring had been undertaken and when we asked a care co-ordinator on duty about this, they told us the person did not require it. We saw from records relating to the person's weight that they had lost over half a stone in weight since March 2017.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's nutritional needs were not properly assessed or provided for in the delivery of care.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.
We found that improvements were required.

We saw that people had mental capacity care plans in place but they were meaningless. In some cases, some of the statements made in relation to people's capacity suggested that their capacity was impaired in all areas of decision making just because they had a mental health issue or learning disability. The mental capacity acts states that people must be assumed to have capacity unless it can be shown to be otherwise. When we checked people's care files however, we found little evidence that people's capacity to make specific decisions was assessed in accordance with the Mental Capacity Act. The DoLS documentation we reviewed was poor and did not show that any best interest meetings had taken place, that any least restrictive options had been explored or that person had been consulted about and involved with the decision to deprive them of their liberty. Without undertaking the proper legal process people were at risk of not having their wishes or rights upheld

For example, a capacity assessment in one person's file did not have the name of the person it belonged to, on it. It lacked sufficient detail about how the assessment to deprive the person of their liberty had been undertaken and their deprivation of liberty safeguard application dated 2016 had not been signed or dated. The outcome of this application was unknown and their previous DoLS had expired.

One person's care file indicated that they were unable to keep themselves safe outside of the home without staff support A DoLS application was submitted to the Local Authority to deprive them of their liberty. Despite this, the person was permitted to leave the home of their own accord without any risk assessment or mental capacity assessment undertaken to show that they were now safe to do so. This meant there was no evidence that the person was now safe to leave the home unaccompanied. On the day of our inspection the person attended a hospital appointment for a serious medical procedure without staff support. Their capacity to consent to, and make an informed decision about this procedure had not been assessed which meant there was no evidence the person had the decision making ability to legally consent to this treatment.

We saw that some people had bed rails in place on their bed. Bed rails are used to prevent people accidentally falling, slipping, sliding or rolling out of bed but require formal consent for use, as they are considered a form or restraint. Despite this there was limited evidence that people's consent had been sought. Where people's capacity to consent to bed rails was in question, a mental capacity and best interest process had not always been followed to ensure that the bed rails installed were in the person's best interests.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

We looked at the arrangements in place to support staff to do their jobs effectively. We found these arrangements to be inconsistent. We looked at seven staff files. Out of the seven staff files only four staff had evidence that they had an induction into their job role when they commenced working at the home. Supervision and appraisal records were limited and did not show that all staff had received appropriate support in their job role. For example, only three staff had evidence that their skills and abilities had been appraised and only five staff had any documentation to show they had received job related supervision.

We reviewed staff training information. We saw that the provider's mandatory training programme covered a range of health and social care topics such as moving and handling, safeguarding, first aid, food hygiene, fire safety, mental capacity, DoLS and dignity in care We saw that the majority of care staff had completed the provider's programme but that the majority of nursing staff had not. We spoke with the manager about this. They told us that it was difficult to get nursing staff to attend the training and when training was organised they did not turn up. This meant that there was a risk that the skills and knowledge of nursing staff was not up to date. It also meant that the registered manager could not be assured that nursing staff continued to meet the professional standards required by the Nursing and Midwifery Council, which is a condition of their ability to practice.

These incidences are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to ensure staff received appropriate support, supervision and appraisal in their job role.

Inadequate

Is the service caring?

Our findings

People's feedback about the staff was mostly positive. One person said the staff are "Very good. They are very friendly". Two other people told us that staff were kind and considerate and one person said that staff were okay but "It is just a job to them".

Relatives we spoke with said staff were friendly and made them feel welcome when they visited. One relative said "I've just been made a cup of coffee and they give feedback about the (name of person's) condition" and another said "I am very happy with the care they (the person) get here".

We saw that the staff were patient and kind when they interacted with people but social communication between them and the people they cared for was minimal. Staff spent the majority of their time completing tasks as opposed to spending time with the people they cared for. In addition people did not always receive the care and attention they needed from staff to keep them safe, promote their independence and ensure they had a good quality of life.

For example, we observed one person trying to eat a hamburger and salad with their fingers. This was not very dignified and did not promote the person's ability to be independent. We asked a staff member on duty about this and they told us the person preferred finger foods. We observed that the person struggled to eat the hamburger for around half an hour without much success. We did not consider this to be appropriate finger food. Finger food is normally food that can be eaten easily with hands, such as small sandwiches, fruit segments, chunky chips and cubes of cheese. Finger food should require little chewing and should be able to be eaten easily.

We observed a number of other people trying to eat their meals with their fingers. We did not see any adaptive cutlery in use so that they could eat independently and in way that promoted their dignity. For example, one person's care plan advised staff that they needed an adaptive cup to enable them to safely drink independently. During our visit, we did not see an adaptive cup being used in order to promote their independence.

We saw that two people should have been sitting on a pressure relief cushions to mitigate risks to their skin integrity but staff had not ensured this was in place and two staff member's discussed a person's toileting needs across the communal lounge. This discussion could be overheard by other people, staff and visitors. This did not show staff respected this person's dignity.

During our visit, we saw that when people had their hair washed, staff took them into the communal lounge afterwards to blow dry their hair. This aspect of personal care was clearly visible to other people who lived at the home, staff and visitors. This did not show that staff respected people's privacy with regards to their personal grooming. This type of personal care would have more dignified and appropriate to have undertaken in their own room or the hairdressing salon available in the home.

These examples are a breach of Regulation 10 the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. People were not always treated with dignity and respect or with due regard to their privacy.

We saw that some people's care files were stored in an unlocked cupboard in the communal lounge areas. This cupboard was accessible to other service users and visitors to the home. We also found a number of people's confidential care records and some of their medication, in a skip outside of the home. This skip and all its contents were accessible to all that entered the grounds of the home. This did not show that people's right to confidentiality was respected or that national guidance and legislation in respect of confidential personal information was followed.

This was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014 as people's information was not kept secure at all times, was accessible to unauthorised persons and was not destroyed in accordance with the Data Protection Act 1998.

None of the care files we looked at contained sufficient information about people's preferences in relation to their end of life care. Staff had not received any training in how to support people who were at the end of their life. This meant that people could not be assured they would receive end of life care in line with their wishes.

Inadequate

Is the service responsive?

Our findings

We viewed nine care files and found there was no evidence of a person centred approach to people's care. Most of the information in people's care files was generic with a little bit of personal information sometimes added at the end of each care plan. People life histories had sometimes been taken but there was no evidence this information had been used to plan their care or ensure that care was tailored to their needs and preferences. Information in people's care files was confusing, contradictory and did not provide sufficient information on how people wished to be cared for. One person's personal care assessment referred to a different person. This did not demonstrate that people's needs and preferences were appropriately assessed so that person centred care could be designed.

When we checked the records relating to the care and support people received we found little evidence that person centred care was provided. For example, one person had continually refused some of their medication for significant periods of time. A fax was sent to the person's doctor in January 2017 with regards to this but there was no evidence that the person's GP had responded. There was no evidence that the person's refusal to take their medication was followed up with the person's doctor until April 2017 and no evidence that any action had been taken thereafter. The person's care plan gave staff no instructions on what action to take in relation to this and there was no evidence that any consideration had been given to the impact this had on the person's health and well-being.

We saw that the one of the medications the person refused to take was in relation to their mental health. We checked their daily records and saw that they regularly experienced negative mental health symptoms and would have needed this medication to be given as prescribed in order to prevent their mental health from deteriorating.

One person's care file stated that they experienced seizures yet their needs in relation to this had not been assessed so that care and treatment could be planned. We saw that the person's care plan advised staff to monitor certain aspects of this person's physical health but there was little evidence any monitoring was undertaken. For example, their care plan advised staff to check the person's blood pressure monthly but records showed it had only been taken once since May 2016.

Other people's care records also showed that they did not receive the person centred care they needed to keep them safe and well. For example, one person's care plan stated they needed to be checked every two hours. We checked a sample of their care records and saw that there were significant gaps of up to ten hours between some of the checks undertaken.

One person's airflow mattress to promote their skin integrity showed a fault. We saw that the alarm notifying the staff of the fault had been turned off and when we checked the mattress it had started to deflate. This meant that no appropriate action had been taken by staff to ensure remedial action was taken to ensure the person's mattress was safe and suitable for use. This placed the person at physical risk of harm. Another person's pressure mattress was set at too high a setting for their weight. Too high or too low a pressure setting for a person's weight can increase their risk of developing a pressure sore as opposed to preventing

it.

The inconsistences we found with regards to people's care demonstrated that staff were not providing care in a consistent and responsive way. We found that some staff lacked adequate knowledge of people's needs in order to be able to respond to them and some staff did not even know who people were. For example, we observed a doctor visit the home. They asked a nurse to take them to a named individual. The nurse took them to the wrong person and had the care co-ordinator not intervened, the doctor would have visited and potentially treated the wrong person.

Not all of the units provided a calm, stimulating or therapeutic environment for people to live in despite this being a statement made in people's care plans. We saw that one person's care plan stated they preferred one to one company and solitude yet on the days we inspected this person spent most of their time in busy communal areas. We saw that on the first day of our inspection this person was very distressed. Care staff tried to intervene but this just made the person's agitation worse. They did not encourage the person to move to a quieter environment to ensure they experienced the solitude they preferred or seek the assistance of a nurse to see if the person required their PRN medication for agitation. When we checked the person's care plan we saw that it contained little guidance to staff on how to support the person when they became distressed.

Only two of the five units we visited in the home provided activities to people on the days that we visited. On day two of our inspection, a singer came into one of the units and sang to people and in another unit staff undertook a ball game with some of the people. We also saw and spoke with a representative from the local church who visited people who lived at the home. They told us they came every two weeks. We did not see the other three units enjoying any activities and when we checked the programme of activities displayed in the entrance area of the home, they did not match what had been provided and the programme did not cover all of the units where people lived.

People's opinions of the activities were mixed. People's comments included "They have sing- a- longs, pretty much for older people. There are lots of people here but nobody my age really"; "I'm fed up, nothing here, nothing to do. I'm not happy". And "Not really (much to do)" and there was nothing they enjoyed. One person said they enjoyed the quizzes.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people who lived at the home did not receive person centred care that met their needs or reflected their preferences.

We looked at the provider's complaints policy in the service user guide. Contact details for the Local Government Ombudsman to whom people could escalate their complaint to needed to be added to the policy but overall the policy was satisfactory.

A relative we spoke with told us that they had previously raised a concern with the registered manager and this had been resolved without delay. This indicated that the registered manager had taken appropriate action but when we checked the manager's complaints records we did not find this was always the case.

For example, we saw that several complaints were received from relatives and staff at the home about the quality and quantity of the food provided to people over 12 month period. One relative had complained in March 2016 and another in August 2016 stated that not enough food was sent up for people's lunch. A third relative also raised concerns that there were only "Six sausages and one tin of beans provided for 16 people; only blended tomatoes and no soft porridge". In October 2016, three staff had complained again that the

quality and quantity of the food provided was poor and further complaint was received in April 2017 which referred to food being 'uncooked". This did not demonstrate that appropriate action had been taken to ensure that complaints about the food served at the home were responded to and addressed in a timely manner.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was no effective complaints system in place to ensure that necessary, proportionate and timely action was taken in response to people's complaints about the service.

Inadequate

Is the service well-led?

Our findings

There were no effective systems in place to monitor the quality and safety of the service. We saw that the registered manager and home manager undertook a range of audits to monitor the quality and safety of the service. This included an audit of care plans, accident and incident audits, meal time audits and medication audits. These audits were ineffective in identifying the serious concerns we found in the delivery and management of the service. When issues with people's care were identified, we found that no effective action had been taken by the registered manager, home manager or provider in order to protect people from potential harm.

For example, we identified serious concerns with the management of medication. The registered manager and home manager acknowledged that they knew that the new medication system was not being used correctly and had issued a letter to clinical staff in March 2017 with regards to this. During our visit however, we identified similar issues with the management and administration of medication. This showed that no effective action had been taken to address the concerns identified.

Contemporaneous and accurate records in relation to people's needs and care were not maintained. Care records were poor and were not appropriately checked, updated or monitored. People's care plans failed to reflect the care they required. Care plan audits were in place but there were ineffective in identifying the discrepancies and inconsistencies in people's care records.

Records in relation to the care and treatment people received had significant gaps and were poorly completed. They did not show people received the care they needed. There was no evidence that people's daily care records were checked or monitored and there was little evidence of any managerial oversight in relation to the care people received. This meant there were no effective management systems in place to enable the registered manager and provider to be assured people received safe and appropriate care.

We found that neither, the registered manager or home manager were a visible presence within the home. The registered manager did not appear to have any clear understanding of what care was provided to each person. When questions were asked about people's care, the registered manager in the majority struggled to answer. For example, we asked how many people who lived at the home had pressure sores, they told us one. During our visit we found at least eight people with pressures sores. We asked if there was anyone who lived at the home who required a catheter. They told us no. We identified three people with a catheter currently in situ. We found the lack of the registered manager's knowledge and lack of management oversight concerning.

Policies and procedures in some instances were not adhered to by staff or the manager. For example, the provider's wound management policy stated that all wounds would be assessed by the registered manager, an individual prescription of care devised and all wounds monitored accordance with this plan. We found little evidence that this policy had been followed.

The provider's recruitment policy clearly stated that at least two satisfactory previous employer references

were required when staff were recruited. When we looked at staff files we found that neither, the registered manager or home manager had followed this process. By failing to follow the policies and procedures in place to keep people safe, people were placed at risk of harm.

We saw limited evidence that people who lived at the home and/or their relatives or staff had been asked for their feedback on the care provided. We saw that a survey of people's satisfaction had been conducted over a year ago but people's feedback had not been analysed in any meaningful way to enable the registered manager and provider to gain an informed view of the service. This meant there was no evidence that people's feedback was used to identify where improvements could be made so that appropriate action could be taken.

During our visit we found concerns with almost every aspect of people's care. When we shared our concerns with the registered manager both during and at the end of the visit. They were not able explain why there were so many issues of concern in the home or give an satisfactory explanation as to why they had not been dealt with, other than to say that they had plans to improve things. We did not consider the service to be well led.

These examples are all breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there were no effective systems or processes in the home to ensure that the service was safe, effective, caring, responsive or well led.

After the inspection we referred our concerns about people's care to the local authority safeguarding team for vulnerable adults. We asked the registered manager and provider for an urgent action plan to be put into place to mitigate the immediate and serious concerns we had identified. An action plan was submitted that advised that emergency work had commenced. We also met with the registered manager and provider alongside the local authority and the NHS clinical commissioning medicines team to express our concerns about the seriousness of the situation. At the time of this report, the home was being supported by the local authority and the clinical commissioning group's medicines team to ensure risks to people's health, safety and welfare were reduced.