Elder Homes Bradford Limited

Duchess Gardens Care Centre

Inspection report

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Ratings

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

Overall summary

The inspection was unannounced and was carried out on 27 January and 2 February 2015. At the time of the inspection there were 54 people receiving care at Duchess Gardens Care Centre.

The last inspection was on 16 July 2014. At that time we found the provider was not meeting a number of the regulations. We told the provider they must take action to make improvements to the way they monitored the quality of the service. We also gave them a warning notice telling them they must take action to make sure medicines were managed safely. We followed up all those areas during this inspection.

Duchess Gardens Care Centre is a converted four floor building in Bingley, West Yorkshire. The centre is registered to provide personal care and nursing to a maximum of 131 people. The centre provides care for older people, people living with dementia and people with long term mental health needs.

Summary of findings

The service did not have a registered manager, the previous registered manager left soon after the inspection in July 2014. 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. There was an acting manager in post at the time of the inspection, prior to accepting the manager's post they had been employed at the home as an administrator.

The continuity of care was compromised because the service did not have enough nurses and the arrangements for providing cover with agency nurses were ad hoc. People's care and welfare was further compromised because the nurses that were employed did not have the right qualifications, knowledge or experience to meet their needs. Medicines were not managed safely and this put people at risk.

People's needs were not always properly assessed and care was not always planned and delivered to meet their individual needs. People did not always get the right support to enable them to eat and drink sufficient amounts to maintain their health. The home had a day centre where people were supported to take part in social activities and there were planned outings to local places of interest. However, there were inconsistencies in the way this aspect of the service was delivered and for many people the opportunities to take part in any meaningful social activities were limited.

We saw positive interactions when staff showed kindness and compassion to the people in their care. However, we also observed people were not always treated with respect and dignity and staff were not always attentive to people's needs.

We saw staff had received training on safe working practices. Staff told us they were receiving more training and this was helping to improve the service. However, there was a lack of training linked to the needs of people using the service which meant staff did not always have the skills and knowledge needed to understand and meet people's needs.

There was a lack of strong and consistent leadership; the service has had a high turnover of managers and senior staff. Lines of communication were not always clear and managers, nurses and senior staff were not aware of what was happening in the home.

The provider had systems in place to monitor and assess the quality of the services provided and to identify, assess and manage risk. However, these systems were not working because they had not identified the serious concerns we found during the inspection.

We found the provider was in breach of a number of regulations. CQC is considering the appropriate regulatory response to resolve the problems we found.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The people we spoke with told us they felt safe. However, people were at risk because medicines were not managed safely. We told the provider about this at previous inspections and they had failed to take appropriate action to protect people.

The home did not have enough nurses and the nurses who were employed did not have the right qualifications, skills and experience to meet the needs of the people who used the service. This meant people were at risk of not receiving safe and appropriate care.

Is the service effective?

Requires Improvement

The service was not always effective. Most people told us they enjoyed the food however, people did not always get the right support to eat and drink enough to maintain their health.

Staff had been trained in safe working practices but had not received training to help them understand and meet the specific needs of people living at the home.

Is the service caring?

Inadequate

The service was not consistently caring. We saw staff showing kindness and compassion to people and supporting people to make choices. However, on other occasions we saw people were not treated with dignity and respect.

End of life care was not planned and delivered to make sure people's wishes were taken into account.

Is the service responsive?

Inadequate

The service was not responsive. People's care plans did not provide up-to-date information about their needs, preferences and risks in relation to their care, support and treatment.

There was an inconsistent approach to providing meaningful activities for people and not enough attention was given to meeting the needs of the people who needed the most support.

Is the service well-led?

Inadequate

The service was not well led. People were not protected because the provider did not have effective systems in place to monitor and assess the quality of the services provided.

The home lacked consistent leadership and communication systems were poor. Managers, nurses and senior staff were not adequately informed and aware of what was happening in the home.

Duchess Gardens Care 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.

The inspection was unannounced and was carried out on 27 January and 2 February 2015.

The inspection team was made up of a pharmacy inspector, two inspectors, an inspection manager 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. On this occasion our expert was experienced in the care of older people.

Before the inspection we reviewed the information we held about the home. This included information from the provider, notifications and speaking with the local authority contracts and safeguarding teams. We also contacted Healthwatch which is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before our inspections we usually ask the provider to send us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask the provider to complete a PIR.

During the inspection we spoke with 15 people who used the service and three relatives of people using the service. We observed how people were cared for and supported in the lounges and we observed the meal service at lunch time. We used the Short Observational Framework for Inspectors (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk to us. We spoke with nine care workers, three nurses, the chef, the acting manager and three of the provider's senior managers. We looked at nine people's care records and 25 people's medication records. We looked at a variety of other records which included four staff recruitment files, training records, meeting notes, maintenance records, accident and incident records, audits and policies and procedures. We looked around the building including a selection of people's bedrooms, communal bathrooms and toilets and the lounges and dining room.

Inadequate

Is the service safe?

Our findings

At previous inspections in August 2013, February 2014 and April 2014, we identified concerns about safe handling of medicines. Following the inspection in April 2014 we issued a warning notice telling the provider that they must take action to protect people by ensuring the safe management of medicines. We inspected the service in July 2014 and found that people were still not protected against the risks associated with the unsafe management of medicines. We invited the provider to a formal interview to explain what actions they had taken to ensure people were protected. They declined our invitation and said they would send us information in writing, however, this information was not sent until after the inspection on 27 January 2015. During the inspection on 27 January 2015 we found that, although some improvements had been made, people were still at risk of harm because of the poor management of medicines.

Appropriate arrangements were still not in place for obtaining medicines. We looked at records about medicines and the medicines for 25 people. We found the records showed four people had run out of one of their medicines, including pain relief, for up to three nights.

Appropriate arrangements were still not in place for recording medicines. Although there had been some improvement in this area we found the records did not always show how much medication was in the home for each person. It was not possible to tell, from the records, if people with swallowing difficulties, who were prescribed thickeners to thicken their fluid to prevent them from choking, were given thickened fluids.

We saw photographic identification was missing for two people who had recently moved into the home. This meant there was a risk staff may not be able to identify them easily before giving medicines. We saw unexplained codes used on the record sheets about medicines making it difficult to tell if people had been given medicines as prescribed. We saw the records about creams were not completed properly; there were lots of gaps making it impossible to tell if creams had been applied as prescribed.

We found appropriate arrangements had not been made in relation to the safe administration of medication. At the last inspections the records showed people were given doses of Paracetamol too close together. There should be a gap of four hours between doses. During this inspection we found staff no longer recorded the actual time that doses of regularly prescribed Paracetamol were given. Therefore, it was impossible to tell if a safe time interval had been left between each dose. We found one person was not given their medicines before leaving the home to attend a planned hospital appointment. This meant they were placed at risk of pain and suffering other symptoms which their medicines were prescribed to prevent.

We saw one person was not being given a food supplement as prescribed and they were losing weight. Another person had been unable to swallow for over 10 days but the doctor had not been contacted to discuss if it was safe for them not to have any medication. The records showed that one person had “lost” a patch they were wearing, to deliver continuous pain relief over a seven day period. Staff could not tell how long the patch had been missing for or what had happened to it. When the stock and the records were looked at together we found some people had not had their medicines as prescribed or the stock could not be accounted for. We also saw people missed having doses of their prescribed medicines at night because they were asleep and staff had failed to take any action to change to a more suitable dose time for each individual person.

We found at the last inspections medicines were not being given properly with regard to food. At this inspection we found arrangements had now been made to give those medicines at the correct times. However, in one person’s records we saw arrangements had not been made to give a newly prescribed medicine as directed by the manufacturer with regard to food.

As at the previous inspections we looked at records for people who were prescribed medicines to be taken “when required”. We found some information was still unavailable to guide staff how to administer medicines prescribed in this way. We found some of the guidance which had been put in place was conflicting and confusing. We saw one person was prescribed an antihistamine which can relieve allergies and itching. There was no guidance in place for the use of these tablets but we noted the person for whom they were prescribed was very itchy and was scratching. There was no information recorded to guide staff when selecting the appropriate dose of medication for each person when a choice of dose was prescribed. It was important this information was recorded to ensure people were given their medicines safely and consistently.

Inadequate

Is the service safe?

We saw audits, checks on how medicines were handled, had been carried out. The last audit was carried out on the nursing unit in December 2014. There was no score on the audit, however the guidelines of the audit stated that a score of less than 90% was a fail and was classified as "red". There was no evidence that any action had been taken following the audit to reduce the risk of the same errors happening in the future.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12(2) (f),(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have enough nurses employed to cover the shifts. There were two nurses employed for day duty, one was contracted to work 48 hours a week and was also the clinical lead nurse. The other day nurse was contracted to work 12 hours a week. There was one nurse contracted to work 42 hours a week on night duty, this equated to four nights. The service was short of 136 nursing hours a week at the time of the inspection. None of the nurses employed had mental health qualifications. At the time of the inspection the provider had just opened up another floor on the nursing unit for people with complex mental health care needs and two people had moved into the unit in the week prior to the inspection. When we looked at how these people were being cared for we found the service was not meeting their needs. For example, we found one person was presenting behaviour which challenged the service and as a consequence they had not been supported with personal care since moving in.

We asked the management team what they were doing about the recruitment of nursing staff. They told us they had one interview arranged and were recruiting some nurses from Italy. They did not have a start date for these nurses. We asked about the recruitment of nurses with a mental health background and they told us the nurses coming from Italy would have done some mental health training but would not necessarily have qualifications in mental health.

The service was using agency nursing staff and the acting manager told us they tried to get the same nurses to maintain continuity of care. However, the provider had not taken measures to ensure continuity of care, for example by arranging to employ specific agency staff on a contract for a set period of time. When we looked at the arrangements for induction for agency staff we found they were not robust. As a minimum an induction for agency nurses should include an orientation to the building and an explanation of the emergency procedures to minimise the risk to people using the service and staff. There were two agency nurses on duty on the day of the inspection, both of whom had worked previous shifts in the home. They told us they had not received an induction and had not been made aware of the fire procedures. When we asked the acting manager about this they showed us induction forms which had been completed by the agency nurses but were not dated. When we checked we found the agency nurses had been asked to complete the induction forms during the course of the inspection and not when they had begun working in the home.

This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the residential unit, where there were 27 people accommodated on three floors, there was a team leader, two seniors and three care staff on duty. The acting manager told us these were the usual staffing numbers. We looked at the duty rosters and found for the most part the service was maintaining these staffing levels. The acting manager told us they had implemented a new system for managing absence and this was helping to maintain the required staffing levels.

One person who used the service said they did not think this was sufficient. They said "Two carers (staff) for 16 people is not enough." A relative told us they felt staff needed more time to be able to speak with and interact with people.

The acting manager told us they did not have a dependency tool to help them assess the numbers and skill mix of staff needed to meet the needs of people. The area manager confirmed the tool they had been using was not fit for purpose and they were looking for an alternative dependency assessment tool.

There was a senior housekeeper and domestic on each unit and separate catering staff were employed.

We looked at four staff recruitment files. The records showed the required checks were completed before new staff started work. This included two written references and Disclosure and Barring Service (DBS) checks. The DBS has

Is the service safe?

replaced the Criminal Records Bureau (CRB) and providers are required to check to make sure potential employees do not have a criminal record which would mean they were not suitable to work in a care setting. The records showed the provider checked to make sure registered nurses were registered to practice with the Nursing and Midwifery Council (NMC). This helped to make sure people were protected from the risks of being cared for by unsuitable staff.

It was sometimes difficult to obtain clear information as management systems were chaotic. For example, on arrival we were told there were seven people living on the second floor of the residential unit. When we arrived on the second floor the team leader told us there were eight people living there. This created a risk that in the event of a fire, inconsistent information might be shared that would put people at risk.

On the second floor of the residential unit we saw one person was not wearing any spectacles. When we looked at their file their photograph showed them wearing glasses. We saw their most recent eye test stated that without glasses the person had 25% vision. The prescription explained this meant the person could not see the TV and was at risk of falls. With glasses the person's vision was 67% and they could see objects in the room. We saw the person was supported to prepare to go out for the day but when they left they still were not wearing glasses. This meant the person was not being supported to minimise risks to them caused by their visual impairment.

The person's sensory care plan stated 'staff to ensure I wear them (glasses) at all times every day and that they are clean'. Their falls risk assessment recorded a high risk of falls and their mobility care plan again stressed the need for them to wear their glasses at all times. This meant staff were not following the person's care plan to ensure their safety and to meet their assessed need. When we asked staff why the person had not been wearing their glasses they told us they sometimes refused. However, we did not see the person being encouraged to wear their glasses whilst at the service or when preparing to go out for the day.

In the records of one person who was receiving respite care there was no personal evacuation plan in place for staff to know the support they required to evacuate the building in the event of a fire.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 (2) (a), (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection we were contacted by West Yorkshire Fire and Rescue Services. They told us they had issued the provider with an enforcement notice to be met by 31 January 2015. The notice related to shortfalls in staff training, maintenance of fire safety equipment, fire escape routes and the use of door wedges to prop fire doors open and the fire risk assessment. They told us they would be visiting the service to check the provider had taken appropriate action to deal with the shortfalls. During our inspection we observed a number of doors were propped open with wedges, we shared this information with the fire officer so they could follow it up on their next visit. During the inspection we saw the provider had put a system in place to ensure checks were carried out on the fire safety systems. This included checks on the fire alarm system, the emergency lights and fire extinguishers. Following the inspection we contacted West Yorkshire Fire and Rescue Services. They told us the provider had taken appropriate action to reduce the risks and most of the work had been completed. They said they had given the provider some extra time to complete the outstanding work and they would be going back to check this had been completed before they deemed the service fully compliant.

We looked at maintenance records and found they were up to date. These included checks on the water systems, gas, electricity and the lifts and hoists.

People who lived at the home told us they felt safe. Most of the staff we spoke with said they received training on safeguarding. They were all aware of how to recognise abuse and how to report any concerns about people's safety and welfare. They were aware of the whistle blowing procedures and knew they could contact external agencies such as the Local Authority of the Care Quality Commission if necessary. Our records showed the service was reporting safeguarding concerns to the Commission and the Local Authority safeguarding team. When we looked at the incident and accident records we saw the service kept copies of the notifications they had submitted.

CQC is considering the appropriate regulatory response to resolve the problems we found.

Requires Improvement

Is the service effective?

Our findings

The home had a training champion who told us they were responsible for making sure staff received the training they needed. Staff told us they felt they had received adequate training and this had improved at the service. Team leaders told us they had received medicines training prior to administering medicines within their team leader role.

The home had a programme of NVQ (National Vocational Qualification) training. Twenty three care workers had obtained an NVQ at level 2 or 3 and a further 20 care staff were enrolled on NVQ training. In addition, two staff were undertaking an NVQ in catering and hospitality and one in level 3 management.

We looked at the training matrix which showed there was a planned programme of training on safe working practices. For example, moving and handling, food hygiene, infection control, first aid, health and safety and fire safety. The training matrix showed the majority of staff were up to date with training on these topics. Other training listed on the matrix included equality & diversity, the safe management of medicines, the Mental Capacity Act and Deprivation of Liberty Safeguards, dementia, falls and fracture prevention in older people and non-violent crisis intervention. The matrix showed only two staff had attended training on falls prevention in older people. The matrix showed the majority of staff had attended dementia training, however, when we asked staff they told us they had not received training on dementia awareness and were not aware of current best practice guidance regarding approaches to care for people living with dementia.

We also found staff did not always have the knowledge or skills to meet people's specific needs. For example, we spoke with staff about how they approached people with a particular form of visual impairment. Staff were not aware of the adjustments they needed to make when approaching the person to ensure they were aware staff were there. One staff member told us, "I am wondering if that contributed to [their] fall as staff may have been directly in front [where the person may not have been able to see them]."

In another instance, one person who had one of their legs heavily bandaged told us they could only have a shower when a particular care worker was on duty because they were the only one who knew how to use the shower shoe to keep the bandages dry.

The provider told us all staff undertook induction training when they started work and the majority of staff we spoke with confirmed this. However, this was not always supported by the records. For example, in the records of a care worker who had started work in November 2014 there was no induction checklist in their file and no record on the training matrix to show they had received induction training.

In another care worker's file we saw they had transferred to Duchess Gardens from another service operated by the provider in July 2014. There was no induction checklist in their file but the training matrix showed they had completed their induction in August 2014. The acting manager told us the care worker had been supernumerary for two six hour shifts when they started work and this was recorded on the computer. The care worker had been promoted to a senior care worker sometime between July and December 2014, however, there was no supervision or appraisal documentation in their file to support this decision.

The acting manager told us the provider's policy on staff supervision was that staff should have a minimum of six supervisions a year. The 2014 supervision plan showed this had not been happening consistently and the acting manager confirmed this. They told us they had put a new supervision and appraisal plan in place. They explained the plan involved the delegation of responsibility for supervisions and appraisals to different grades of staff such as the nursing staff, team leaders and heads of department.

This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the residential unit we saw people's weight was monitored. Where people were identified as losing weight their care plan identified the need for additional snacks between meals. Where people had sustained weight loss we saw they had been prescribed food supplements.

Is the service effective?

However, we noted in one person's care records they had been prescribed a supplement that had not been given for 28 days. Records showed this person had consistently lost weight since May 2014.

We saw another person had been prescribed a food supplement on an evening. On the day of our visit staff recorded this was not given as the person was out on a trip. The trip took place during the day and should therefore not have impacted on the person's ability to take it. The person had lost weight between December 2014 and January 2015.

Where people required their dietary intake to be monitored we saw this was done. However, records only showed the type of food eaten and/or offered rather than the amount taken. This meant it was not possible to identify those people who had not eaten sufficient to meet their dietary requirements.

People's fluid intake was also recorded where a risk of dehydration had been identified. The amounts were not calculated to check that people were having enough fluids or to take action where they were not. We saw for one person they had been recorded as having 100ml of fluid over a 24 hour period. Recorded fluid intake on other dates ranged from 1400ml to 2200ml.

One person on the residential unit described the food as, "It's lovely." Another person told us a cooked breakfast was available every day which they enjoyed.

On the nursing unit we also looked at how people were supported to meet their nutritional needs. In one person's records we saw their weight in December 2014 had been recorded on two separate forms and the records were different. One record stated the person's weight was 75.10kg and on the other showed it was 61.10kg. The person's nutritional risk assessment was last reviewed in January 2015, no date, and showed the person had a low risk of malnutrition. The person's eating and drinking care plan had also been reviewed in January 2015 and stated no changes were needed to the care plan. There was nothing recorded in the care plan or nutritional assessment to indicate the person reviewing the records had identified the discrepancy in the weight records. The person's care plan stated they should be on a fluid/food chart and staff should monitor their weight. On the first day of the inspection, 27 January 2015 there was no fluid/food chart in place for this person. On the second day of the inspection we found fluid/food charts had been started on 29 January 2015. The charts did have information to guide staff on how much the person should be drinking in a day. Two of the four charts completed had been added up and showed the person had an intake of 1400mls over 24 hours.

In the records of another person we saw their weight in October 2014 was 53.5 kg, in December 2014 it was 41.3kg and in January 2015 it was 39.8kg. The person's care plan said they should be given "adequate hydration" but there was no guidance for staff on what this meant. There was an entry in the nursing records dated 21 January 2015 which stated the person was not eating and drinking at all and that they had experienced a seizure at night. However, the records showed the person had not been seen by their GP since 17 November 2014.

In the records of another person, who had insulin dependent diabetes, we saw they had lost 9.2kg between December 2014 and January 2015. The nutrition care plan stated the person's weight should be monitored. The record said the person's GP was aware of their weight loss; however, there was no information to show what, if any, action was being taken with regard to the person's weight loss.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home operated a four weekly menu cycle. The chef told us the menus were developed at the provider's head office but were adapted at the home to reflect people's preferences. There was a board in the kitchen where people's special dietary needs were recorded. For example, it showed people who required a diabetic or vegetarian diet and people who required a pureed diet. The board did not have any information about people who required their diet supplementing because of weight loss. The chef explained they were not given information about individuals but were asked to provide extras on a floor by floor basis, for example they might be told the top floor needed two jugs of milk shakes and 200mls of cream.

Requires Improvement

Is the service effective?

We observed the lunch time meal service in the dining room on the first floor of the nursing unit. The menu, which was written in small print, was on a board in the dining room. Staff told us there were seven people who had their food pureed and there were six people who needed staff to support them with eating. There were no chairs in the dining room; staff told us they had been moved into people's bedrooms for their visitors. Three people had their meals in the dining room, two people we in reclining chairs and the third person sat at the table on their own.

We also observed the lunch time meal service on the ground floor of the residential unit. Five people had their meal in the dining room and four people stayed in lounge. Preparations started at 12.30pm but the meal service did not start until 1.10pm in the dining room and people who were eating in the lounge areas were served after that. This meant the people in the dining room had to wait over 30 minutes, we noticed the room was slightly cool and lacked any atmosphere. The radio was not switched on until 1.10pm when staff started to serve food, and then it was very loud which made conversation difficult. We heard one person complaining they had been waiting too long.

The meal service was not particularly well organised, for example in the dining room people were served with juice and tea at the same time along with their food. In the lounge we saw people were given cups of tea before their food was served and they had difficulty manoeuvring the cups and plates on the small tables.

We asked people if they enjoyed the food, one person said, "The food is better now and we have a choice but they are not always sensible combinations." They said the previous week they had been given quiche with hot vegetables rather than salad. Another person said, "The food is ok" and a third person said, "The food is good and varied."

People's ability to make decisions was considered as part of the care planning process. Where people lacked capacity to make decisions about their care a best interest decision was recorded within their care records confirming that their care plan was in their best interest. Where people needed support to make day to day decisions care records stated people needed the support of staff or family to help them with this.

One person in the residential unit had a DoLS (Deprivation of Liberty Safeguards) in place that had been authorised. We saw records for a respite client where the provider had previously applied for a DoLS authorisation but following assessment this had been refused. This showed the service recognised the need to apply for DoLS authorisations when people were deprived of their liberty in order to keep them safe.

We saw one person had made arrangements for their family member to take legal responsibility for the management of their property and affairs. Their care records had a copy of the documentation to show the arrangement was lawful.

In the records of one person on the nursing unit a capacity assessment had been completed which showed the person lacked capacity to make complex decisions about their care and treatment. However, when we looked at the DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) form it showed the person had been involved in making the decision. We asked the acting manager to look into this.

We found there were key pads restricting access at every door between units and at the front door. This meant people's freedom to move around the home was restricted. A number of small restrictions can combine to create a deprivation of liberty. **We recommend the provider takes account of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice.**

People's care records showed they were supported to access health professionals to help maintain their health and well-being. This included their GP and district nurse as well as opticians

We observed one person coughed on a regular basis when eating and drinking. We saw this at breakfast, during the morning and at lunch. On one occasion staff supported the person by rubbing their back and advising them to take small sips when taking a drink. We asked staff if any consideration had been given to the possibility of the person needing a speech and language therapy (SALT) assessment, in case the person's swallowing ability was impaired. Staff told us they had not considered this as the person had asthma and had a new inhaler, though this was not improving their cough.

When we checked the person's records we found they had been treated for a chest infection in November 2014 and January 2015. We asked the acting manager to consider the need for a SALT referral as part of our feedback on the day of our inspection.

Requires Improvement

Is the service effective?

CQC is considering the appropriate regulatory response to resolve the problems we found.

Inadequate

Is the service caring?

Our findings

People we spoke with told us they were satisfied with their care. One person told us all the staff were kind and caring and that, "We work as a team…….I am happy in Duchess Gardens Care Centre. I would never leave."

Another person told us, "It's lovely here they take care of me and my family are very happy. The staff are very kind and we have a joke. They are good during the night."

We observed one person eating their breakfast independently in the lounge area. They were slow to eat. Staff offered assistance and checked with the person that they did not require any assistance at regular intervals. When the person told them they were fine staff respected this and allowed them to continue to eat independently.

We observed staff interacting in a way which showed kindness and compassion, for example holding someone by the hand and offering assurances.

On the residential unit when supporting people to transfer from a wheelchair to a chair, we observed staff gave very clear verbal instruction and reassurance to people.

However, we also observed practices which showed a lack of respect for people and undermined their dignity. For example, we saw one person was given two tablets to chew but they did not have their teeth in and found it difficult. We noticed several other people did not have their teeth in.

On the nursing unit we observed one person being assisted to move with a stand aid hoist by two care workers. The person was dressed but their top had ridden up exposing their stomach and we saw their hair was dishevelled. One of the care workers did not speak to the person at all and the other just said, "Going up". We saw the person's right hand kept slipping off the hoist and staff put it back on, the person was making agitated sounds. The person was assisted to sit in an armchair; the pressure cushion on the chair was stained with what looked like dried food. When the person was seated we observed they had food stains all round their mouth and on their slippers. In addition, we saw the legs of the bed table, which was in front of their chair, were stained with food.

People were not always supported to maintain their dignity. For example, one person had a runny nose. They looked around for any tissues but there were none within reach. The person then resorted to wiping their nose on their sleeve. After lunch, in another part of the home we saw a person sitting in the lounge with dried food all around their mouth and chin. Staff did not offer support to the person to clean their face until we asked them to. We observed the name staff were using to address this person was not the same as the name on their care records. When we checked we found the name staff were using was not the person's name nor had they expressed a preference to be addressed in that way.

During the afternoon we observed care in the lounge of the ground floor nursing unit. We saw staff giving people hot drinks to two people. One person said, "I don't like sugar, why do you keep bringing me it?" The care worker offered the person another drink which they accepted. The person told us this happened all the time. There was a third person in the lounge and staff did not offer them a hot drink. As the care worker was about the leave the room we asked if the person was going to be offered a hot drink. The care worker then offered the person a drink and retuned with a cup of tea. The person then asked for biscuits and again the care worker went to get them.

At 5.20pm on the first day of the inspection we saw one person sat in the lounge in their pyjamas, they told us they hadn't had their tea yet. We also saw another person walking down the corridor in their pyjamas.

There was no menu on display on the second floor of the residential unit. When we asked staff about any menu board they told us the menu was usually displayed on a board. When we looked at the board we saw the last date on the board was in November 2014. People ordered their meal the day before it was on the menu. On the day of our visit we saw orders were taken for the following day in the late morning before lunch. This did not help people living with dementia to retain information about the food that was available to them on the day.

We later observed a staff member ask one person about the portion size they wanted at lunchtime. The staff member asked the person, "Do you want a small portion or a large portion?" The person responded, "What of?" The person was then asked again what portion size they wanted rather than what the lunch was. When the person asked again what food they were referring to the staff member responded, "Shepherd's pie; small, medium, or large? Answer me [person's name], do you want small,

Is the service caring?

medium or large?" The person was not given time to respond before the staff member asked another five questions about lunch before telling the person they would come back.

We also saw a menu board in the dining room on the ground floor of the residential unit. A person who used the service told us it was never updated and said it was in the wrong place for people to see.

Care records showed people and their families were consulted as part of the care planning and review process. However prior to our visit people living with dementia had been moved from the lower ground floor where they were able to access the garden area to the second floor. The acting manager told us this was to allow the service to develop a new service on the lower ground floor. We spoke with one person about how they had been consulted and involved in this decision. They told us they had been told they were moving as the ground floor was closing rather than asked if they wanted to move. They had then been able to choose their own bedroom.

Although care records included sections for people's life stories these had not always been fully completed.

Throughout the day of our visit we were able to access the nurses' stations and people's care records as the rooms were unlocked and records were not securely stored. This meant people could not be assured their right to confidentiality was protected.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff on the residential unit explained that when people had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) there was a code on the outside of their care file. They said this meant it was easy for staff to check this information, for example in the case of an emergency or if the person had to go to hospital.

On the nursing unit there was no coding system in place and staff told us they had to look in each person's care records to find this information. This meant the information was not readily available to staff in an emergency and was particularly of concern because of the number of agency nursing staff the service was using.

In one person's records there was an end of life care plan dated August 2014. The person had a DNACPR in place. The care plan had information about anticipatory medicines and physical care needs but no information about the person's wishes. It was reviewed in September 2014 and stated the person's end of life wishes should be discussed with their family when they next visited. It was reviewed again in January 2015 and no changes were made. When we looked at the complaints records we saw the person's family had visited in October 2014, they had raised some concerns about their care which had been addressed. However, there was no evidence the service had taken the opportunity to speak with the person's relatives about their end of life care.

In the records of another person who also had a DNACPR our findings were similar. Their end of life care plan had no information about their wishes and/or preferences. The care plan had been reviewed in January 2015 and no changes had been made although it was evident from the other care records that the person's needs had changed. We asked the clinical lead nurse about this and they said they were waiting for the GP to visit before updating the care plan.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 (3) (b),(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the acting manager and they told us they had arranged for staff to receive training on end of life care. On the second day of the inspection end of life care training was taking place and the acting manager confirmed further training sessions had been booked.

CQC is considering the appropriate regulatory response to resolve the problems we found.

Inadequate

Is the service responsive?

Our findings

The care records followed the same format for each person and were indexed making it easier to find the relevant section of people's files when looking for information.

In one person's care records, in the residential unit, we saw a statement 'At times I can become agitated'. However, the records did not record any triggers for this or the actions staff should take to support the person to manage any anxiety. This meant staff were not provided with information in order to inform their approach to the person to help them avoid potentially challenging situations.

In care records we saw terms describing people as 'wandersome'. Some of the records we looked at showed a task rather than person focussed approach. For instance, there was reference to 'toileting' people rather than supporting them to use the toilet. In another person's care records we saw within the person's 'This is Me' document staff had recorded, 'At times I am a pleasant lady.' This did not provide a sense that the person was valued and respected.

Care records were reviewed on a regular basis on the residential unit. Although, we found one person who was receiving respite care did not have complete care records. This included a lack of a photograph to help staff identify the person in their care plan and medicines administration records. We saw the person had previously stayed at the service.

Care records included a section to record 'My activities'. We found in two of the four files we looked at in the residential unit that this was blank or incomplete.

In one person's records, in the nursing unit, we saw a pressure sore risk assessment (Waterlow) dated January 2015 which showed they had a "very high risk" of developing pressure sores. The pressure care chart stated the pressure relief mattress should be set at 90kg. When we checked we saw the mattress was set at 150kg. The person's weight was recorded on the BMI (Body Mass Index) chart in December 2014 as 61.10kg. The mattress was not set correctly and therefore would not be working effectively to relieve pressure thus increasing the person's risk of developing a pressure sore.

We looked at the person's personal hygiene care plan which showed they needed special creams to maintain their skin integrity. The care plan reviews dated November, December 2014 and January 2015 stated "Bottom remains sore." There was no change to the care plan and no evidence of action taken to address this.

We saw a moving and handling assessment for this person which had last been reviewed in January 2015. It stated they needed a stand aid hoist and should be assisted by two staff "to assure as can be aggressive/un-cooperative". We observed the person being transferred by two staff using a stand aid and they did not provide any reassurance, one of the care workers did not speak to the person at all and the other just said "Going up". Throughout the process we observed the person was making sounds which suggested they were agitated. This showed the person's care was not being delivered in line with their care plan.

In the records of another person in the nursing unit we saw a pressure sore risk assessment (Waterlow) dated 4 January 2015. This showed the person had a "very high risk" of developing pressure sores. The care plan did not have any information about the setting for the pressure relief mattress and there was no reference to a pressure relief cushion or the recliner chair which we saw the person was using. The person's pressure care chart stated the mattress should be set at 50kg. However, when we looked at the person's weight records we saw their weight was recorded as 39.8.kg in January 2015. When we checked the mattress we saw it was set at 30kg which meant it would not work effectively to reduce the risk of the person developing a pressure sore.

We observed the person sitting in the dining room in a recliner chair. We saw the setting on the pressure relief cushion was set below 30kg. We asked one of the senior care workers what the cushion should be set at and they replied it should be set at 70kg and adjusted it. We asked the care worker how they knew what the setting should be. The replied they didn't know how the setting was decided but said they just knew it should be 70kg. We pointed out that the person's charts which were in the dining room stated that the pressure mattress should be set to 50kgs and asked if the cushion should be the same. The care worker replied that they didn't know. The care worker then said they had set the cushion at 70kg so that it would pump up quicker.

This demonstrated the person's care was not being planned and delivered in such a way as to ensure their safety and welfare and meet their individual needs.

Inadequate

Is the service responsive?

We looked at the records of a person who had recently moved into the nursing unit at Duchess Gardens. An assessment completed by the Local Authority before they moved in provided detailed information about their care needs. The assessment showed the person had a history of mental illness, had a number of physical health issues and presented behaviour which could be challenging.

We looked at the pre-admission form which was in the person's care file; it was not dated or signed. We asked the clinical lead nurse about the pre-admission assessment for this person. They told us the pre-admission had been done by the manager of another home operated by the provider. Duchess Gardens did not have any nursing staff with qualifications in caring for people with mental health care needs. However, in spite of the absence of suitably qualified and experienced staff the service agreed to provide care for this person. This demonstrated the provider had not taken proper steps to make sure that the assessment process was sufficiently robust to protect people against the risks of receiving unsafe or inappropriate care or treatment.

The person's care notes showed that since admission they had refused care and treatment. On 27 January 2015 when we looked at their records there was very little information about their care needs. The clinical lead nurse told us they were working on the care documentation. We saw the person in their bedroom. There was a strong offensive odour, the person told us they had not been in the home long and it was all new to them. On 2 February 2015 we looked again at this person's care. The clinical lead nurse told us the person was still refusing to accept care and treatment. We asked the clinical lead nurse if they felt the service could meet the person's needs and they said they had, "Mixed feelings" about whether or not they could meet the person's care and treatment needs. We looked at care plan about personal care; there was no clear information to guide staff on how they should support the person with this aspect of their care. A care plan about communication had also been completed, we found this also failed to provide clear guidance for staff, for example it stated "offer assistance when required". This showed the person's care was not being planned and delivered in such a way as to ensure their safety and welfare and meet their individual needs.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 (1) and (3) (a),(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within the residential unit we saw there were limited opportunities for people to engage in meaningful activity. One person's care records showed they had previously enjoyed household domestic tasks but there was no record in their care plan that this formed any part of their support plan. People were not routinely encouraged to share in domestic tasks such as setting tables or clearing up after meals. Another person's care records showed they had enjoyed entering competitions. There was no plan in the person's care records to provide opportunities to complete or enter competitions.

The service had a day centre and employed separate activities staff. A visitor told us they did activities and crafts in the day centre and they took their relative in there when they visited. They said they had been told each floor had a crafts box but said staff didn't seem to have the time to do any activities with people.

A number of the people we spoke with told us they enjoyed regular outings to place such as the Royal Armouries and local garden centres.

On the first day of the inspection there was a "pet therapy" session, this was done by a volunteer who told us they brought their dog in to visit twice a week. They said, "The lounges seem too hot so everyone is sleepy." They also said it would be nice if the TVs were turned off sometimes and people were given the opportunity to listen to music.

On the nursing unit on the first morning of the inspection we observed six people sitting in the lounge. The TV was on; a care worker walked into the lounge, put two jugs of juice on the windowsill, spoke briefly to one person and then left. A little later another staff member came in and asked one person if they wanted to go on a trip to the Royal Armouries. Another person asked if they could go too, they were told they could. We asked the second person if they were looking forward to going out and they said they were.

Inadequate

Is the service responsive?

We then asked if they went out much and they replied, “There’s not as much going on as there used to be.” We asked what they used to do and they replied, “I used to go swimming I liked that.” They told us this had stopped last year.

On the top floor of the nursing unit we saw a sensory room but it was locked. We asked one of the staff about it and they said they didn’t know where the key was and added they had never seen the room being used.

We did not see any other activities for people taking place on the nursing unit. We observed people in the lounge areas spent their time sleeping or watching TV.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints procedure and this was displayed in the reception area of the home.

We looked at the complaints records. The acting manager told us they had dealt with three complaints since taking up their post in October 2014. The records showed the complaints had been investigated and feedback had been given to the complainant.

CQC is considering the appropriate regulatory response to resolve the problems we found.

Inadequate

Is the service well-led?

Our findings

The home had a new acting manager who had been in post since October 2014. The previous registered manager left soon after the last inspection in July 2014. The new manager was not new to the service; they had worked at the home for some time in the role of administrator. They told us they were going to apply for registration with the Commission.

Staff told us they thought the new manager was bringing a lot of changes and they were forming team bonds, "So we are all singing off the same hymn sheet."

We asked people living at the home if they knew who was in charge and none of them knew who the manager was. They told us they would speak to one of the care workers if they had any worries.

People living with dementia had been transferred from the lower ground floor to the second floor as part of the provider's re-organisation of the service. This move had recently taken place. However, we found the furniture in the lounge to be badly damaged and in need of replacement or repair. The seating cushion of one settee was completely shredded exposing the sponge pad within. The pad was soiled with what appeared to be faecal matter. Staff told us this had been reported but did not know if there were any plans to replace it.

Also in the lounge we saw a chair with a pressure relieving cushion. A protective incontinence pad had been placed on the cushion and remained there throughout our visit. It was not clear whether this was there to replace a damaged seating pad or to meet somebody's assessed needs. The seat was not used during the morning of our visit. However, if intended for pressure relief the pad would have reduced the efficacy of the pressure relieving cushion.

The staff office on the second floor of the residential unit was chaotic. The door was unlocked throughout our visit. Historic medication administration records were strewn across the desk; there was an open pack of incontinence pads and a wheelchair cushion on the floor. This did not inspire confidence in the organisational and leadership skills of the management team.

Lines of communication were not always clear. On the nursing unit care staff told us they no longer had a handover at the start of their shift. They said only the nursing staff attended the handover. They said this had been implemented about a month before the inspection. They said it meant care staff did not always know what was going on. For example, on one occasion they didn't know a person had fallen in the night and when they tried to get the person up it was obvious they were in pain because they cried out. They said the person went to hospital after they reported this to the nurse in charge. We asked the acting manager about the handover arrangements on the nursing unit. They and the area manager confirmed they had implemented the change about a month before the inspection because of concerns about the absence of care staff on the floors when handover was taking place. The staff were employed to work from 8am to 8pm which meant that in the morning for example, when the night staff left at 8am there were no staff on the floor until the handover had finished. The managers told us the nurses were supposed to share information with the senior care workers after the handover and they in turn were supposed to cascade this information to the rest of the care team. The information we had been given by staff suggested this was not happening. In addition, we shared our concerns that the management team and senior staff had no way of monitoring the timeliness, accuracy or quality of the information that was being cascaded. This risked people not receiving safe and appropriate care and treatment.

When we spoke with the chef they told us there were not given information about the individual dietary needs of people who were nutritionally at risk or had experienced weight loss. They had not seen the weight loss action plan which the clinical lead nurse had put in place. The chef told us staff just had to ask and they could provide people with more or less whatever they needed or wanted to eat. However, when we spoke to staff it was clear they didn't always know what they could ask the kitchen for. This contributed to people not receiving the right support to meet their nutritional needs.

The nursing unit consisting of four floors did not have a working telephone land line at the time of the inspection. The management team told us the land line had not been working for several months and they were waiting for an external contractor to rectify the problem. There was one mobile phone for all four floors. This meant the only way staff on different floors could communicate with each other was by going from one floor to the next. Staff told us if they needed support in an emergency they would use the call bell system. The acting manager told us people's relatives

Inadequate

Is the service well-led?

and external professionals had been given the mobile phone number. They added people could also phone the landline to the office and a message would then be passed to the nursing unit and if required they would be called back. This created a risk of, at the least, inconvenience and, at worst, to delays in responding to emergencies.

Staff told us people were paying for their own fish and chips when these were served as the main meal of the day. We asked the acting manager about this. They told us people who used the service had said in a recent survey that they would like more fish and chips on the menu. In response they had arranged for a weekly trip to the local chip shop and confirmed people were asked to pay for fish and chips provided in this way.

One person who used the service told us they had completed a quality assurance survey in November 2014, but added, "Nothing every changes".

Although the provider had systems in place to assess and monitor the quality of service provision we found these were ineffective and had failed to identify and address the serious issues and concerns we identified at this inspection.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is considering the appropriate regulatory response to resolve the problems we found.