Delph House Ltd

# Delph House Limited

**Inspection report**

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## Ratings

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

## Overall summary

This inspection took place on 5, 6 and 9 October 2015 and was unannounced.

Delph House Limited is a nursing care home for 39 older people some of whom may be living with dementia in Broadstone, Poole. At the time of the inspection 31 people were living at the home and 19 of these people were receiving nursing care.

The registered manager left the service in July 2015 and the new manager had applied to be registered at the time of the inspection. The new manager had been in post since the end of June 2015. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

# Summary of findings

At the last comprehensive inspection in May 2015 this provider was placed into special measures by CQC. This inspection found that there was not enough improvement in the service to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to the shortfalls we found.

In addition to placing the service in special measures in May 2015 we served three warning notices on the previous registered manager and provider in relation to serious shortfalls in medicines management, the care people received and the governance of the service.

We required these warning notices to be met by 14 August 2015. These warning notices in relation to medicines, the care people received and the governance of the home have not been met.

At this inspection we identified seven repeated breaches and one new breach of the regulations.

Any risks to people's safety were not consistently assessed and managed to minimise risks. Their needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. People did not always receive the supervision, care and treatment they needed and this placed them at risk. People particularly at risk were those receiving end of life care, those nutritionally at risk, those with vulnerable skin and those with complex physical care and nursing needs. Some people's health care needs were not always met because the healthcare support they needed was not delivered. Some people did not have access to call bells so they could seek assistance from staff. These shortfalls were repeated breaches of the regulations.

A small number of people were not always treated with respect and their dignity was not maintained. This was a new breach of the regulations. Overall, staff were caring and were respectful in the way they treated and spoke with people.

People's medicines were not always safely managed or administered. This was because some people did not have their creams applied as prescribed and staff did not have clear instructions when they needed to give some people 'as needed' medicines. This meant some people may have received sedative medicines when they did not need it. This was a repeated breach of the regulations. There were improvements in the storage and recording systems for medicines.

People's mealtime experiences were varied. People did not all receive the monitoring, support and fortified fluids and food they needed to increase or maintain their weight. This was a repeated breach of the regulations.

There were not enough staff to meet people's needs. This was because most people at the home needed two staff to safely care for them. The manager told us as a result of the inspection they had increased the staffing levels. This was repeated breach of the regulations.

Some risks in the building such as the use of oil filled radiators and stair gates were not assessed or safely managed. In addition the risks of some staff working unsupervised had not been assessed or managed. This was a repeated breach of the regulations.

Staff still did not fully understand the principles of the Mental Capacity act 2005 particularly where people had the capacity to make decisions. This was a repeated breach of the regulations.

The manager had not notified us of all of the significant events that had happened at the home. This was a repeated breach of the regulations.

The home was still not well-led. The manager and registered provider had been providing us with a monthly action plan as to how they were going to meet the regulations. There were some improvements in the monitoring systems in place at the home. However, the management of the home was still reactive rather than proactive. When we identified shortfalls and risks to people they were addressed. The systems in place for assessing and monitoring the quality and safety of the service were still not effective. This was because the shortfalls we found had not been identified by the manager and registered provider.

Activities were provided and most people had opportunities to be occupied.

Staff recruitment practices were safe and relevant checks had been completed before staff worked with people.

# Summary of findings

Staff told us they had attended training since the last inspection. Staff felt supported but had not had formal meetings to review their performance. This was an area for improvement.

People and relatives knew how to make a complaint and complaints were investigated. However, there was not a clear system for recording complaints and it was not clear how learning from complaints was consistently shared with staff. This was an area for improvement.

# 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**

People were still not kept safe at the home.

Risks to people were not managed to make sure they received the correct care they needed. Other risks in the building were not managed or addressed.

The management and administration of medicines was not consistently safe.

Staff were recruited safely.

Staff knew how to report any allegations of abuse.

**Is the service effective?**

**Inadequate**

People's needs were still not met effectively.

Appropriate arrangements were not in place to obtain people's consent or, if they were unable to give consent to particular aspects of their care, make decisions on their behalf in line with the Mental Capacity Act 2005.

Some people did not have their weight monitored to ensure they received sufficient food and drink to make sure their nutritional needs were met.

Some people's health care needs were not met to ensure that they kept well.

People were referred to specialist healthcare professionals when needed.

**Is the service caring?**

**Requires improvement**

The service was caring but needed some improvement. This was because staff did not always respect some people's dignity.

End of life care plans were not in place for one person so staff could provide them with the correct care.

People and their relatives told us staff were kind and caring.

**Is the service responsive?**

**Requires improvement**

The service was still not responsive to people and their needs and needed to be improved.

People did not always receive the care they needed, their care plans were not always updated and did not include sufficient information about their care and support needs. This meant staff did not have up to date information about how to care for people.

People and relatives knew how to make a complaint but these were not consistently recorded.

**Is the service well-led?**

**Inadequate**

The home was still not well-led.

# Summary of findings

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

Staff and relatives were consulted about the service during meetings.

# Delph House Limited

**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 5, 6 and 9 October 2015 and was unannounced. Two inspectors attended on the three days of inspection. A specialist advisor whose expertise was in nursing care of older people attended on the third day of the inspection.

We met and spoke with all 31 people living at the home. Because a small number of the people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five visiting relatives and with the manager, the registered provider, eight staff and a visiting GP.

We looked at eight people's care and support records, 12 people's medication administration records and other documents about how the service was managed. These included five staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Before the inspection we reviewed the information we held about the home. We also spoke with the local authority and Clinical Commissioning Group (CCG) contract monitoring and safeguarding teams.

Following the inspection, the manager sent us information we asked for about policies and procedures, staff calculation tool and staff training.

Inadequate

# Is the service safe?

## Our findings

At our inspection in May 2015 we found there were not enough nursing staff on duty to meet people's needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, there were six care staff on duty and a registered nurse during the day and four care staff and a registered nurse at night. In addition to this the manager who is a registered nurse worked Monday to Friday 7.30 am to 5 pm, and the activity worker worked Tuesday to Saturday.

The manager told us they had appointed two registered nurses to job share the deputy manager's post. The registered nurses had not started work at the time of the inspection.

There were not enough staff to meet people needs. We observed and people told us they needed to wait for care and support. For example, on the third day of inspection one person told us they were waiting to get up at 10.30am and another person said they were still waiting to get up at 10.40am. A third person called out and staff were not available to respond to them. A fourth person was to be monitored at all times when they were in a communal area because of the risk of them falling. We observed this person unsupervised in the lounge on three occasions during the three days of inspection. A fifth person was to be monitored every half an hour due to them walking around the home to and from the lounge area and their bedroom. The monitoring records for this person showed this had not happened.

The manager went through all of the people's personal care and moving and handling needs with us. They told us that 28 of the 31 people living at the home needed two staff to support them with moving, repositioning and personal care. Some of these people were living with dementia and required high levels of staff supervision. Three of the people were independently mobile and needed one member of staff to assist with their personal care.

Following the inspection the manager sent us the tool they used to calculate the staffing levels needed. However, this did not take into account that people needed two staff to support them and these people stayed in their bedrooms rather than used communal areas. The manager also confirmed following the inspection that staffing had been increased by one member of staff. However they had not identified this shortfall before our inspection and this was a repeated breach of the regulations.

These shortfalls in the staffing levels and deployment were a repeated breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in May 2015 there were shortfalls in the risk management for people, medicines management, ensuring the premises are safe and preventing and controlling the spread of infection. This was a breach of Regulation 12 (2) (a)(b)(d)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served a warning notice to the previous registered manager and provider in relation to medicines management. They were required to meet Regulation 12 (2) (g) by 13 August 2015.

At this inspection we observed staff member put a tablet in one person's mouth, who was very sleepy. The staff member said, "chew this" and walked off. Another staff member was also in the lounge writing records. The person said quietly, "I'm being poisoned, help, drink of water". The staff did not respond. We intervened and asked the staff member to check whether the person had swallowed the tablet, they had not and the staff gave them a drink to help them swallow their tablet. This person did not receive the support they needed to take their medicines safely.

Another person was prescribed sedative medicines for when they were unsettled or anxious. This had been administered on five occasions over a period of two weeks. This person had some complex behavioural needs and was being supported by the specialist mental health team. However, the 'as needed' medicines plan did not include when and in what circumstances to administer the medicine. In addition to this the medicine or daily records did not detail the reasons or circumstances why this had been administered. A member of agency nursing staff told us, "If a drugs there it's to be used. I am mostly the only one that uses it. I may have a shorter fuse." This practice placed this person at risk of inappropriate use of a sedative medicine.

Inadequate

# Is the service safe?

As identified at the last inspection some people's cream application records were still not consistently completed to show whether people had their creams applied as prescribed.

The storage of medicines had improved. New medicines storage had been installed, covert medicine and as needed plans (PRN) were in place for people. Most of these had enough details so that staff knew how and when to administer medicines to people. Robust systems were in place in checking the stocks of medicines that required specialist storage and management.

Risks to people were not consistently managed to make sure they were kept safe from harm. The manager had recently assessed the risks of stair gates being used across three people's bedroom doors. This was following a visit from a professional that raised concerns about their use. The rationale for using these stair gates was not the least restrictive option and other options had not been considered. We were told the stair gates were in place to prevent other people walking uninvited into these people's bedrooms. However, staff told us there was not anyone living at the home that was likely to do this but there had been previously. This meant the risks had not been reassessed when the circumstances changed.

Two people had been identified as needing high levels of support and monitoring. One person's care plan detailed they needed to be checked every half hour and another person was to be supervised at all times when they were in the lounge. The first person's monitoring records showed they were not checked every half an hour as required.

The second person was left unsupervised three times during the first and second day of the inspection. They were left unsupervised for five minutes during our observations on the second day of the inspection. The manager told us the staff had said to the manager they thought that because we were sat in the lounge it was ok to leave the person unsupervised. However, CQC staff are not responsible for the care, support and supervision of people during inspections. The other two occasions the person was unsupervised when we visited the lounge to check whether staff were present.

At our last inspection we identified that the provider and previous registered manager had not referred one staff member to their professional body following a safeguarding investigation. At this inspection the manager had made this referral and had completed a medicines competency assessment with this staff member. However, the staff member was now working unsupervised within the home. The manager had not assessed the risks of this or implemented any formal way of monitoring the safety of this situation apart from meeting with the staff member to discuss their performance.

On the first day of the inspection prescribed drink thickeners were not stored securely to minimise the risks of people having access to it. The manager had identified this risk in August 2015. The staff spoken with were not aware of the risks in relation to this thickener and the harm if it was ingested. Staff took immediate action and the thickener was stored securely in people's bedroom for the remainder of the inspection.

At the last inspection we found risks in the building were not managed and this included radiators that were not covered and the balustrade on the first floor landing was lower than modern standards and may present a risk to people. At this inspection works had been completed to raise the height of the balustrade and radiators were covered. There were portable oil filled radiators in two people's bedrooms. Risk assessments were available regarding these radiators but they did not relate to the people whose bedrooms they were in. This meant the risks of using these oil filled radiators had not been assessed or managed for these people.

These shortfalls in the risk management, medicines management and ensuring the premises are safe were a breach of Regulation 12 (2) (a)(b)(d)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to told us they felt safe. Relatives told us they also felt their family members were safe at the home.

There was information displayed on noticeboards about how people, visitors could report any allegations of abuse to the local authority.

Staff had been trained in safeguarding as part of their induction. All of the staff we spoke with were confident of the types of the abuse and how to report any allegations. Following our last inspection the safeguarding policy had been reviewed and updated.

Inadequate

# Is the service safe?

We looked at five staff recruitment records. Recruitment practices were safe and relevant checks had been completed before staff worked with people. This included up to date criminal record checks, fitness to work questionnaires, nursing registration numbers, proof of identity and right to work in the United Kingdom and references from appropriate sources, such as current or most recent employers. Staff had filled in application forms to demonstrate that they had relevant skills and experience and any gaps in their employment history were explained. This made sure that people were protected as far as possible from individuals who were known to be unsuitable.

There were emergency plans in place for the home and building maintenance. In addition to this there were weekly maintenance checks of the fire system and water temperatures. There were robust systems in place for the maintenance of the building and equipment.

Inadequate

# Is the service effective?

## Our findings

At our inspection in May 2015 we identified the staff lacked an awareness of the principles of the Mental Capacity Act 2005 and the lack of mental capacity assessments and best interest decisions was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection some staff still did not have a full and working understanding of the principles of the Mental Capacity Act 2005. Following discussion with two people, a relative and staff we found two people had fluctuating capacity in relation to making some decisions. For example, one person told us they were uncomfortable on the air mattress they were lying on and they did not like having the bed rails up. This person was able to recall this conversation with us and told their relative the next day they had spoken with us. Staff also confirmed this person was able to make some decisions. The person had also been assessed as having capacity in relation to a Deprivation of Liberty Safeguards (DoLS) application. This information was not reflected in the care plan and they and their relative told us they had not been consulted and involved in making decisions in relation to the care plans in place.

Another person had a DNACPR (Do not attempt CPR) decision and bed rails in place. However, the person had not been involved in making these decisions and the DNACPR record included the person did not have the capacity to make this decisions. However, this person was able to tell us their views on living at the home and the care they received and how it was managed. Staff also told us this person would be able to make these decisions.

A third person had an advocate appointed to be consulted when any best interest decisions were needed to be made. The most recent best interest decision recorded by the manager included they would consult with the person's advocate. However, there were not any records of who this person was and no action had been taken to contact the person's funding authority to establish who the advocate was. This meant this decision had not been made in line with the act.

These continued shortfalls in the staff's understanding of the principles of the Mental Capacity Act 2005 were a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Some of the people living at the service had been assessed as lacking mental capacity due to them living with dementia. DoLS applications had been completed and submitted to the local authority by the previous registered manager. During the inspection the manager acknowledged that DoLS applications may have been submitted to the wrong authority and the records in place did not give all the information needed about the applications. Following the inspection the manager provided us with an update on who had an application submitted to the local authorities. However, this information was not easily accessible in people's care plans so staff would know who was being deprived of their liberties and had an application submitted. This was an area for improvement.

At our inspection in May 2015 we found shortfalls in meeting people's nutritional and hydration needs which were a breach of Regulation 14 (4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had lost weight and records did not detail whether people were receiving fortified foods.

At this inspection some people's nutritional and hydration needs were still not fully met.

One person's dentures went missing in August 2015. At the time of the inspection in October 2015 the person still do not have any dentures. This person had lost 7.6 Kg since their admission into the home in April 2015 and had been referred to the dietician for advice. They told us they used to eat highly flavoured foods at home. They said, "I really like chicken curry and rice, if the food was different and more like I had at home I would eat more". The manager had audited this person's care plan in June 2015 and

identified they needed a dental appointment. However, the person's missing teeth had not been identified as a shortfall when the manager reviewed this person's care plan again in September 2015.

A second person's records in their bedroom included they needed to have their fluids thickened. Staff confirmed they were thickening this person's fluids. However, there was not a SALT (Speech and Language Therapist) assessment or plan for this or a plan written by the nursing staff at the home. Staff and records were not able to explain who had determined what thickness this person's fluids needed to be thickened to. The manager told us the SALT had visited but this had not been recorded. This person's care records and care plans made reference to concerns about their fluid intake but their fluid intake and output was not being monitored.

On the first day of inspection the manager told us they were concerned about a third person and they suspected they had a urine infection and that they were monitoring their food and fluids. Staff were not monitoring this person's food and fluid intake and no records were kept. This person appeared unwell and sleepy throughout the inspection. We advised the manager at the end of the first day that staff were not monitoring this person's fluid intake. The manager took action and staff started to record this person's fluid intake. However, we reviewed these records on the last day of the inspection and the records had not been reviewed to check whether the person was drinking enough.

A fourth person had lost a total 9 kg of weight since moving into the home in February 2015. They had seen the SALT in June 2015 and had nutritional supplements prescribed. The chef told us this person was receiving a high calorie diet. However, the person had continued to lose another 1.3 kg since June 2015. The most recent care plan included that this person needed to be weighed weekly but their last weight was recorded on 14 September 2015. This person's food intake was not being recorded to ensure they were eating enough food and to record what fortified foods they were receiving. In addition to this on two separate days of the inspection the person had a beaker with a spout on it and their SALT care plan detailed they needed an open beaker. We identified this to staff because this placed this person at risk of choking.

For some people there was good monitoring of their food and fluid intake. However, this was not consistent. Some people's fluid records had not been totalled or reviewed to make sure action was taken if they had not drunk enough fluids.

People who were sat in the nursing lounge were not offered a choice of drinks during the main meal. Some staff did not explain to people what they were eating whilst others did.

These shortfalls in the monitoring of and supporting and meeting people's nutritional and hydration needs were a repeated breach of Regulation 14 (4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives spoke highly of the quality of the meals and all of the people except one person told us they were happy with the choices on offer. The cook had a good understanding of people's specialist diets and who needed high calorie diets or their foods fortified with additional creams, cheese and milk powders. The cook told us they consulted with people by meeting with them and or their relatives and recorded their likes and dislikes and incorporating these into the menus. In addition to this they had sent questionnaire to people and they had analysed the results.

At our inspection in May 2015 people did not receive effective nursing care to meet some of their health needs. These shortfalls in accurately assessing, planning and meeting people's care and nursing needs were a breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection some people still did not receive the care they needed to maintain their health.

One person had been discharged from hospital back to the home and whilst in hospital their diabetes had been unstable. The person's updated diabetic plan included they needed to have their blood sugars monitored four times a day before meals. However, records showed this monitoring did not take place. This meant staff were not monitoring the person so they could respond and take action if the person's blood sugars were not in an acceptable range.

Another person had a catheter that needed to be changed every 12 weeks and this was detailed in their care plan. The person's catheter had been due to be changed during the

third week in September 2015. Records showed this had not happened and their catheter was not changed until 8 October 2015 when the catheter was not working properly. The manufacture's sticker with the catheter's reference and lot number was not retained and included in the person's records when it was changed on 8 October 2015. This person did not receive the treatment they needed and that was planned.

We observed two people sitting in hoist slings that were not designed to be left in situ. We checked their care plans and the slings were only to be used for moving people. Leaving people sat in hoist slings that are not in situ slings increases the risks of pressure areas developing on people's skin.

One person was in bed with their feet pressed up against the base of the bed. They were not able to reposition their feet because of the way they were in the bed. No padding or cushioning had been provided to reduce the risks of pressure damage to this person's feet. We brought this to the attention of the staff and manager.

These shortfalls in accurately assessing, planning and meeting people's care and nursing needs were a repeated breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there was an improvement in the management of some people's wounds. For example, one person's wounds, who we had previously identified concerns about, had healed and their pressure area care was now well managed.

Overall, people's pain was now well managed and staff were using a pain assessment tool to check whether people needed their pain relief. Records showed people were receiving their pain relief as prescribed.

People were referred to healthcare professionals once healthcare issues had been identified. For example, people were referred to dieticians, physiotherapists, community psychiatric nurses and tissue viability nurses.

We spoke with a visiting GP who told us the recent changes in staff had unsettled the home and this had impacted on the robustness of the ordering of medicines from the GP practice. This had been problematic but they had raised this with the manager and hoped the issue was going to be resolved. The GP did not have any concerns about the care people had received but identified there was potentially an over liaison with the GP practice about people's medical concerns. They acknowledged that this may have been in response to the concerns identified during the last inspection.

At our last inspection there were shortfalls in the staff's skills and experience to provide safe care to people and this was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, records showed staff completed core training, for example, infection control, moving and handling, safeguarding, fire safety, health and safety and food hygiene. Staff spoke positively about the training they had received since the last inspection. This included training on nutrition, wound dressings, medicines and the Mental Capacity Act. Some of this training was face to face and some was watching DVD's and completing workbooks. At our last inspection we identified concerns about wound management. Some dressing training had been provided by a dressings company but specific wound and pressure area management training had not yet been provided.

Overall, staff told us they felt well supported and listened to by their line managers.

The manager told us they had not been able to complete a training plan for the home because most staff had not had a one to one supervision session or appraisal. They said they had completed one to one supervisions with two staff and they had a plan in place for the remainder of the staff. The manager told us they did not have plans to formally supervise any agency staff but planned to observe them in practice whilst on duty. The lack of a training plan, formal one to one supervisions, and development and appraisal sessions for staff was an area for improvement.

Requires improvement

# Is the service caring?

## Our findings

We observed one person who was fully dressed in bed at 10 am. The person was living with dementia and could not recall why they were fully dressed. They told us they wanted to get out of bed so we sought assistance for them. Staff told us they had dressed the person at 8am and they were waiting for another staff member to be free to assist them getting the person out of bed. This practice was not dignified.

In the main staff treated people respectfully and included them in conversations. However, we observed some staff talking to each other over people's heads whilst they were supporting them to eat. We also observed some staff ignoring one person who was calling out from their bedroom and another person who quietly said "help me" in the nursing lounge.

At our last inspection there were a number of communal records in use which meant there was not an individual record in place for people. At this inspection, there was a communal bath record book that was left outside the nursing office and was easily visible. This included personal information about whether people had a bath or shower. This information was not included in their personal care records.

A relative told us their family member had been dressed in other people's clothing and although this had been raised it continued to happen.

These shortfalls in maintaining people's privacy, dignity and treating them with respect were a breach of Regulation 10 (1)(2)9a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was discharged from hospital on 2 October 2015 and the handover records identified on 4 October 2015 that the person was receiving end of life care. We observed staff were caring and compassionate in the way they supported and cared for the person and their spouse. However, there was not an end of life care plan put in place to make sure staff knew what care to provide to the person. Staff confirmed the person was nearing the end of their life and needed specific care and treatment to keep them comfortable. We raised this serious concern with the manager who ensured that an end of life care plan was put in place immediately. This lack of care planning for this person at the end of their life was a repeated breach of Regulation 9 (1)(a)(b)(c) (3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some relatives told us before and during the inspection they had not been involved in people's care planning. This was an area for improvement.

People who were able to told us staff were caring. This was supported by relatives; a relative told us "I feel that all the helpers and domestic staff are very caring and friendly."

We saw most staff supported people in a sensitive and caring way. They did not rush people and chatted with them. During activities people and staff smiled and laughed with each other and there was a friendly atmosphere.

Relatives and visitors told us they were free to visit the home and they were always made to feel welcome.

Requires improvement

# Is the service responsive?

## Our findings

At our inspection in May 2015 we found that the shortfalls in accurately assessing, planning and meeting people's care and nursing needs were a breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice to the registered manager and provider in relation to this.

At this inspection, the manager told us they had agreed an extension to review people's care plans with the local authority contract monitoring team. However, the manager had not fully understood that these breaches in the regulations were subject to a warning notice from CQC and this had to be met by 13 August 2015.

People's needs were assessed prior to their admission or readmission to the home. However, this information was not consistently used to develop a plan of care. For example, the manager had re-assessed one person's needs before they were discharged from hospital. The assessment identified the person was not eating and drinking, had a catheter fitted and was not responding to interactions from other people. However, no mouth care and catheter care plan or monitoring was put in place. Staff told us they were providing mouth care. There was not a care plan to guide staff how and how often they should do this and records showed that this mouth care was not consistently provided. There was not a catheter care plan or monitoring records in place so that staff knew how to provide the correct care in relation to this and to make sure the catheter was working. The manager put these plans in place following us raising our concerns with them.

Every person had a care plan and there were some improvements in the details included in people's care plans. However, some people's care plans did not include all of their identified nursing, care, social and emotional well-being needs and included conflicting or confusing information. This resulted and impacted on the quality of care that some people received. For example, one person had a contracted hand and they had a hand protector and specialist hand splint. There were photographs on the person's bedroom wall indicating they should have their palm protector placed in their hand. We asked staff about this and they did not know when or how often this protection should be in place. They told us the night staff took it out. There was a care plan in place for the specialist splint that detailed if the person refused to have this on twice a day the staff should contact the GP. However, records were not maintained about this or this was not followed up with the GP. This person's thumb nail on their contracted hand was long and was dirty. Their finger nails on their other hand were also long. There was not a plan in place for how staff were to support and manage this person's nail and hand care. Staff spoken with were unclear about the arrangements for this person's nail and hand care.

A second person was having their fluid intake monitored and they had a catheter output record. However, the records were not totalled or cross referenced so staff could respond if the person's catheter was not working properly.

We saw another person had a wound on their leg. Staff told us this person frequently scratched their legs. However, the last record of any marks on this person's legs was on 20 September 2015 when bruising was recorded on a body map. This body map had not been reviewed to see whether the wound had healed. There was no record of the leg wound in the daily records and there was not any evidence that the wound had been assessed or treated.

There was little information about people's personal histories and preferences. The manager told us they had asked families to provide this information but this was not yet in place. Staff knew some people well but there were a number of new staff that were not aware of people's information. This meant staff were not able to provide fully personalised care to people.

During the inspection two people, on different days, did not have their call bells within their reach and they wanted assistance. We moved the call bells so they could seek assistance. We waited with them until staff arrived. They arrived promptly and spoke with people but because both people needed two staff to assist them they had to wait until another staff member was available. For one person this wait was over 20 minutes. This meant the staff were not able to be responsive to people's needs.

These shortfalls in accurately assessing, planning and meeting people's care and nursing needs were a repeated breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities co-ordinator who worked Tuesday to Saturday each week. People told us and we saw they enjoyed the activities on offer. The activities worker spent

Requires improvement

# Is the service responsive?

time with people who were cared for or stayed in their bedrooms every morning. There was a timetable of activities displayed in the main foyer of the home and we saw staff let people know what activities were on offer. During the inspection there were quizzes and a visiting animal group where people had the opportunity to interact with a barn owl, a giant millipede, snakes and ferrets. One person who was reluctant to leave their bedroom had attended the activity and told us "I really enjoyed it". Staff were very enthused that this person had left their bedroom to attend.

At our last inspection we found shortfalls in operating an effective complaints system and this was a breach of Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they knew how to complain. Relatives we spoke with during the inspection told us overall any concerns they raised where addressed. However, one relative had contacted us prior to this inspection to raise concerns. They had raised concerns with the home manager and initially improvements had been noted but these had not been sustained.

At this inspection records showed complaints were investigated and some of the complaints outcomes included action plans to minimise the risk of reoccurrence. However, the complaints were not consistently recorded in the complaints system so the manager could easily review them. The learning from complaints was not consistently embedded into practice at the home. This was an area for improvement.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection in May 2015 we found shortfalls in the governance, management of risks, record keeping, acting on feedback from relevant persons and the lack of improvement planning were a breach of Regulation 17 (1)(2)(a)(b)(c)(e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served a warning notice to the previous registered manager and provider in relation to this and they were required to meet this part of the regulation by 13 August 2015. In addition to this we required the provider to give us monthly action plan updates. This was so we could monitor the progress on meeting the shortfalls we identified.

At this inspection, the manager acknowledged they had not yet completed all of the actions identified at our last inspection but they had a plan in place. They told us they had agreed an extension to this with the local authority contract monitoring team. However, the manager had not fully understood that these breaches in the regulations were subject to a warning notice and this had to be met by 13 August 2015.

Although there were improved monitoring systems in place these systems still had not identified the shortfalls we found at this inspection. The audits in place were complex, kept in multiple locations and files and information was not consistently recorded in the records it related to. For example, the manager told us about a complaint they had investigated but this was recorded within the accident and incident records. Medicine audits were kept in different filing systems and an audit completed in July 2015 stated the next audit needed to be completed in August 2015. This audit was found in a separate file. It was not clear how actions from these audits could be tracked to make sure they had been completed.

The local authority and Clinical Commissioning Group contract monitoring teams had been undertaking support visits to the home on a fortnightly basis. They raised concerns with us prior to the inspection that the progress on meeting the shortfalls identified was not being sustained and there were continued concerns about the management of the service.

Following the last inspection the registered provider appointed management consultants to review the service. The management consultants visited and reviewed the service and identified areas for improvement and the progress made with meeting the regulations. However, these reviews did not identify all of the shortfalls we identified at this inspection.

The manager told us in their monthly action plans sent to us and during the inspection that there was a system in place to ensure that monitoring records were checked every day. This was to make sure that any concerns about people's food, fluid, bowel management or cream application was identified and acted on. However, we reviewed people's monitoring records and found these had not been consistently checked and acted on. For example, we found shortfalls in people's prescribed cream application records, their fluid and food record, half hourly checks and repositioning records.

The manager told us they were in the process of reviewing and auditing people's care plans. They directed us to look at one person's care plan who they had fully reviewed. We identified shortfalls in this person's plan including a lack of detail about the use of a hand protector, the person's SALT assessments and plan and how the person's nail care was to be managed and monitored. This meant the care plan audit and review system was not fully effective.

The manager had a monthly complaints auditing system in place. However, not all the complaints were recorded so they were not accurately able to audit the effectiveness of any actions put in place.

Records were not accurately maintained and each person did not have a contemporaneous record of the care and support provided. We found shortfalls in monitoring records. The continued use of communal records meant there was not a complete record for each person. Some records were inaccurate. For example, the repositioning records for one person detailed they were sat up but when we spoke with them they were lying on their left side with cushions behind their back and legs. The person told us and staff confirmed the person could not reposition themselves without staff assistance.

We reviewed the accidents and incidents and found that they had been reviewed by the manager and for some actions had been taken. There was an overall improvement but this was not consistent. For example, one person had significant bruising on their hip but there was not any follow up or investigation as to how this had occurred.

Inadequate

# Is the service well-led?

Another incident had occurred where four staff had provided one person with personal care because they were so distressed and upset. However, there was not analysis of this and there was not any plan in place for how to support this person in future when they were upset.

Most relatives told us they felt listened to and any concerns they identified were addressed but this was inconsistent. Some relatives who contacted us prior to and during the inspection told us improvements were not always sustained. One relative raised concerns about laundry and that they had raised this but there had not been any improvement.

There was not a consistent system to ensure that actions and learning from complaints, incidents and accidents was shared with staff so that it became part of their practice. There were some examples of where actions had been identified and recorded in the staff communication book and handover records. However, information about one person who needed to be observed at all times following a fall had not been communicated to all staff. This had resulted in the person being left unsupervised.

The auditing and monitoring systems did not feed into an overall improvement plan for the service.

These shortfalls in the leadership and governance of the home were a repeated breach of Regulation 17 (1)(2)(a)(b)(c)(e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in May 2105 we found there was a lack of notifications from the registered person and this was a breach of Regulations 18 (2)(a)(b) (e)(4)(4A)(a)(b) of the Care Quality Commission (Registration) Regulations 2009.

The manager had notified us about most incidents they needed to. However, we did not receive a notification about a medicines error that due to the type of medicine should have been reported to us. This was a repeated breach of the regulations.

From 1 April 2015 providers have to display the home's ratings. For the first two days of the inspection the rating was not displayed. We raised this with the manager and provider who told us the inspection report was available by the nursing office. This was not easily visible to people and visitors as detailed in the guidance and regulations. The manager and provider were not aware of the new regulation about displaying ratings. We showed the manager and provider the guidance and regulation on our website. The rating was displayed as required on the third day of the inspection.

Staff told us they felt supported by the manager. Staff were aware of how to whistleblow and had recently been reissued with the policy.

The manager said that they had improved the ways handovers between staff were recorded including voice recording the handovers. In addition a written handover record was kept.

The manager had held a 'residents meeting' and there was a quarterly newsletter for people and their visitors.

The manager informed us they keep their practices up to date by linking in with local provider and partnership group and they maintained their registration as a nurse.