Martlane Limited

# Forest Place Nursing Home

## Inspection report

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03 February 2016

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This inspection took place on 1, 2 and 3 February 2016.

Forest Place Nursing Home is registered to provide accommodation with nursing or personal care for up to 90 people, some of whom may be living with dementia. There were 83 people receiving a service on the day of our inspection.

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

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not protected from the risk of harm. Risk management plans for individual people were either not in place or were inaccurate and so did not support people's safety. Staff did not use equipment safely to limit people's risk of injury or take action to protect people from risks in the environment they lived in. Staff knowledge of how to safeguard people varied and staff had not acted to protect people from the risk of harm. People's medicines were not safely managed. Staff recruitment procedures were not robust to ensure staff were suitable to work with people living in the service. Staff were not always available in sufficient numbers to meet people's needs and to provide them with safe care and support. Improvements were needed to staff deployment to ensure people's safety was consistently monitored.

Up to date guidance about protecting people's rights had not been followed so as to support decisions

made on people's behalf and to comply with legislation. Staff did not receive suitable training and support to enable them to meet people's needs effectively. Staff performance was not suitably monitored and appraised to ensure good practice was in place. We observed poor care practices around supporting people to eat and drink well, with moving and handling of people and with supporting people with anxious and distressed behaviours.

People were not always treated in a caring and respectful way. Records were not always available to guide staff on how to meet people's assessed care needs. People did not always receive the support required to meet their identified individual needs and to support their decisions and choices. People had limited opportunities to participate in social activities and engage in positive interactions.

The service was not well led and there were widespread shortfalls. While people living and working in the service had the opportunity to say how they felt about the home and the service it provided, action plans were not developed to demonstrate that improvements were implemented. Management arrangements to ensure accountability and communication in the service were weak and resulted in a poor care outcomes for people. The provider did not have robust systems in place to monitor and reassure themselves of the quality and safety of the service provided so that timely action plans could be put in in place where needed.

## 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.

Systems to manage risk for people living and working in the service were not safe. Recruitment processes were not demonstrated as robust. People's medicines were not always managed safely.

There were not always enough staff to meet people's needs safely and improvements were needed to staff deployment and accountability.

The provider's systems to manage safeguarding concerns were not effectively implemented.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff were not provided with a level of training and on-going supervision to enable them to meet people's needs well. Staff communication and accountability systems were not effective.

Care staff did not have an understanding of the Mental Capacity Act or the Deprivation of Liberty Safeguards and how this affected people living in the service. Guidance was not being followed to ensure that people were supported appropriately in regards to their ability to make decisions.

Improvements were needed so that people were encouraged and supported to eat and drink sufficient amounts to help them maintain a healthy balanced diet. Systems were in place to support people's healthcare management.

### Is the service caring?

**Inadequate**

The service was not caring.

People were not always asked about their preferences and on-going decisions relating to their care. People did not always receive care in line with their assessed needs.

Some staff demonstrated a lack of respect, compassion and interest in the people they cared for.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People's care was not planned so that staff had guidance to follow to provide people with consistent person centred care.

Improvements were required to ensure that all people who lived at the service received the opportunity to participate in meaningful activities and social engagement that met their needs.

The arrangements in place to deal with comments and complaints were not always followed to demonstrate that people's views were responded to appropriately and promptly.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was a lack of managerial oversight, leadership and accountability in the service overall that meant people did not receive a safe and caring service.

The quality assurance system was not effective and had not identified risks to people's safety and well-being or taken action to address this.

People's views were not used effectively to improve the quality of the care and service people experienced.

# Forest Place Nursing Home

**Detailed findings**

## Background to this inspection

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

This inspection was unannounced. It was undertaken by two inspectors on each of the three days and who were accompanied on the first inspection day by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and in this case people living with dementia.

Before the inspection, we looked at information that we had received about the service. This included information we received from the local authority and any notifications from the provider. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection process, we spoke with fourteen people who received a service and seven of their visitors. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We also spoke with the registered manager, the provider's representative, twelve staff working in the service and three visiting professionals.

We looked at 14 people's care records and 20 people's medicines records. We looked at records relating to six staff. We also looked at the provider's arrangements for supporting staff, managing complaints and monitoring and assessing the quality of the services provided at the home.

Inadequate

# Is the service safe?

## Our findings

While some people told us that they felt safe or their relative was safe in the service, this did not concur with our findings. One person told us for example that they felt safe in the service and said, "The night staff come in and check I'm alright". However we found that people did not receive a safe service. Due to our level of concern at the inspection especially relating to moving and handling practices, we reported this to the local safeguarding authority who is responsible for investigating circumstances where people may be at risk.

Suitable equipment was not used to keep people and staff safe. On Kingfisher 1 unit, we saw a member of staff move a person who was seated in a wheelchair that did not have any foot plates attached for the person to rest their feet upon. This meant that the person's feet, which were bare, were at risk of rubbing along the floor potentially causing friction burns or other further more severe entrapment injury while they were being moved around the building in their wheelchair. We observed that the person had wounds on their feet. We intervened to stop this manoeuvre and to arrange for the footplates to be found for the person's wheelchair. The person's records and a nurse in charge of the unit later confirmed that the person already had pressure ulcers on their heels and wounds on their feet. When we discussed the above practice with staff, a staff member told us, "Sometimes the night staff don't put them on."

We saw staff support another person to transfer from their wheelchair to an armchair by lifting them up under their arms. This is not a safe way of assisting people and can result in injury to the person and the staff. The person's risk assessment gave staff clear instruction that the person was to be assisted to transfer safely using identified equipment. Staff told us that they often lifted the person and other people in this way. Explanations for this action given by staff were that they were afraid that the person would fall from the transferring equipment as it did not fit them, that some people became very upset when equipment was used or that sometimes it was because staff were very busy. This showed that staff were unaware of the associated risks involved with mobilising people without the correct equipment in place and unaware of how this compromised people's safety.

On Maple unit we saw that one person's mattress was set at the highest setting while the person's records showed they were very slight in weight which would require a low setting. Their records further showed that they were at risk of developing pressure ulcers and that the pressure relieving mattress was in place. The incorrect use of the mattress presented an increase to the person's risk of developing pressure ulcers. The records for another person on Maple Unit indicated the person was receiving end of life care. Their pressure mattress was set for a person weighing 40 kilograms despite the person's weight was recorded as being 51kilograms just three days earlier. On Kingfisher 1 unit, a person's pressure relieving mattress showed a low pressure alarm light and emitted a bleeping sound over the three days of our inspection. This was despite our drawing to it the attention of staff on each of the three inspection days and being reassured that it had been attended to. The failure of the pump could result in greater pressure being put on the person's body and increase their likelihood of pressure area damage. Staff response was to repeatedly change the pressure setting of the mattress whether it was safe for the person or not and they were unable to tell us what the correct setting for this equipment should be for the person to support their safe care. Staff did not seek appropriate support to enable them to manage the person's care safely.

On Maple unit, we saw that bedrails were fitted to one person's bed and the bedrail covers were laid on the bed ready for use. Accident records from August 2014 showed that the person suffered a skin tear from the bedrails and from November 2015 showed that the person had found their way through the gap between the bedrail and the bedframe, sustained a skin tear and a graze and was put back into bed and the wound cleaned. The person's records further showed that consent for the person's bedrails to prevent them falling out of bed had been signed for by a relative in April 2012 and showed no record of review. The consent record stated that the person did not want to use bedrails. The risk assessment stated that bedrails were the best solution for the person, however it also stated that the bedrail was not fitted properly and additionally that the person's physical size and behaviour presented a risk to the use of bedrails. This showed that where risk was identified, action was not undertaken to review and mitigate the risk to ensure the person's safety.

People's medicines were not safely managed, administered or accurately recorded which placed them at risk of harm. On one day of our inspection we saw a plastic pot containing four tablets left on a shelf in the dining room of Kingfisher 1 unit. It was not under staff supervision at all times and was accessible to people who were mobile and living with dementia and who could have taken tablets that were not prescribed for them. On another occasion we saw that tablets had been decanted into two identical plastic pots and then stored in the medicines trolley. There were no names on the pots to identify who the medicines were prescribed for. The nurse confirmed that the medicines were for two different people however the medication administration record for one of these people recorded that they had already received their medication. This put them at risk of receiving too much medication. Additionally, both people were at risk of receiving medication that was not prescribed for them.

On the third day of our inspection, Medication Administration Records [MAR] for 18 people within Kingfisher 1, 2 and Maple Down were reviewed. On both Kingfisher 1 and Maple units there were discrepancies as to how frequently one person was to receive some of their prescribed medicines. Discrepancies were found and related to MAR forms not being signed by the registered nurse in five out of eight instances on Kingfisher 1. The registered nurse advised that the reason for not signing all MAR forms was that they had been constantly interrupted by other staff whilst administering people's medication. On one occasion the MAR form showed that one person's medication had been signed as administered but the medication remained in its original package. This meant that the person had not received their prescribed medicines placing their health at risk.

One person was receiving their medicines covertly. There was no written agreement from relevant professionals, such as the GP or pharmacist in line with current guidelines from the National Institute for Clinical Excellence [NICE]; to confirm that the properties of the medicines were not altered when given in this way. There was no clear medicines guidance for staff on how to administer their medicines covertly. This put the person at risk of harm.

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

People were not cared for in an environment that promoted their safety. A main corridor carpet on Maple unit was lifted and rucked presenting a falls risk. One person, who had recent skin tears and wounds on their feet and legs, was sleeping in a bed with a broken footboard with a protruding wooden slat. The registered manager could not assure us that the person's leg injuries had not been caused by the broken bed because they were unaware of the condition of the person's bed. The provider's representative arranged for the bed to be replaced when we made them aware of it. Three bedroom fire doors were wedged open which meant in the event of a fire the automatic door closure system could not operate effectively, putting people at risk. The temperature of hot water was very high in sluice rooms. These rooms were accessible to people living

with dementia and this placed them at risk of scalding injuries. People were not always protected from the risk of infection. Furniture in some areas was in poor condition with surfaces that were not easily cleaned. The surface on one person's chairside table was chipped away on all edges and there was dried food congealed in the edges. We saw bedrail protectors, walls and bedsheets that were stained and dirty. The plastic surfaces of bedrail protectors were cracked or split which meant the surfaces could not be cleaned thoroughly to prevent risk of cross infection.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment processes were not safe in all instances to ensure staff were suitable before working at the service. A full employment history was not always clearly identified and there was no record to show that an explanation of the gaps had been explored. The dates that staff started working at the service were recorded differently in different places and indicated that they had been employed before criminal records checks had been received by the service. The registered manager was unable to provide any evidence to show that suitable assessments had been undertaken to assess the risk to people when staff worked in the service without having these checks in place. This meant that the provider could not be sure that all staff were of suitable character and competence to work with people who use the service.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels and deployment of staff was not suitable to meet people's assessed needs. We found that some people were at risk of being unable to gain help and support when they needed it. We saw that some people spent much of their day alone in their rooms being checked and provided with personal care on a scheduled basis. Staff told us they checked people on a two hourly basis. This was confirmed by relatives. When we questioned the safety of this staff then told us they checked people more often but did not record this. We saw that some people did not have access to a call bell to summon assistance when they needed it. One person asked us to pass them their call bell which had been placed out of their reach.

Our observations showed that staff were not suitably deployed to meet people's needs and keep them safe. Records of complaint and safeguarding investigations evidenced that staff deployment was not always suitable. While a system of staff allocation was in place in Kingfisher 1 and Maple units, it did not ensure that people were supervised and able to access staff support when required. One person, who the registered manager later told us required one to one staff support, was mobilised from the lounge, again with no footplates on their wheelchair. We saw this same person still sitting in their wheelchair without footplates in a small lounge where they were unable to call for assistance 45 minutes later. There was one other person in this lounge. There were no lights on, no television or music playing. The other person told us they needed support with personal care. They had no other way to make the request had we not entered that lounge and intervened. There were no staff present in this lounge on most occasions during our three day inspection.

We received varied views on the suitability of the staffing levels. Some relatives told us there were not enough staff especially during staff break times and at weekends. One relative told us that after ringing the call bell and waiting for staff, they found four staff sitting together having a break and this was why support was not available. One relative who otherwise spoke positively about the staff told us, "At times it is a bit thin on the ground, but at other times plenty." Another relative said, "There always seem to be when I'm here." Staff told us that staffing levels were suitable to allow them to complete their tasks and care for people. However staff also told us that that they were sometimes busy which resulted in them not using safe moving and handling procedures or were interrupted during medicines rounds which resulted in medicines errors.

The registered manager told us that staffing levels were based on the needs of the people using the service and they were aware that staffing levels needed to be increased. They were unable to provide any evidence to show that staffing levels were suited to people's needs or took into account for example, that some people required three or more staff for their repositioning and personal care needs and that many of the other people in the service required two staff for all of their interventions. The registered manager told us that four people required one to one support from staff and that while applications had, or were being made to the commissioning authorities for the additional funding to enable this increased staffing level, it was not currently in place. Records from November 2015 showed that the service had agreed with the specialist dementia team that one to one care was to commence for one person during the evening. The registered manager told us they were unaware of this and it was not in place.

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

Staff had an inconstant understanding and knowledge of how to keep people safe from the risk of abuse. We received information in September 2015 that a person living at the service had left the service unsupervised and had later been returned by the police. This was confirmed by the registered manager who was unaware at the time of the incident that they needed to refer this to the local safeguarding authority until we explained it to them. At this inspection, the registered manager confirmed their understanding of safeguarding issues and their responsibilities in reporting such issues to the local authority. However, the level of unsafe practice we identified and reported to the local authority safeguarding team during our inspection demonstrated that the registered manager and staff did not have a clear understanding of what constituted abuse and they were not committed to reporting concerns to ensure that people were safeguarded.

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

Inadequate

# Is the service effective?

## Our findings

Assessments of people's capacity had not been consistently completed in line with the Mental Capacity Act 2005 (MCA) where decisions had been made about their care and treatment. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Records showed that people had had their capacity to make some day to day decisions, such as relating to personal care and nutritional support, assessed. However, these were generic and the registered manager confirmed that assessments were not in place on an individual basis where needed, for example in relation to the use of the bedrails and a lap belt. One person was receiving their medicines covertly, that is without their knowledge. There was no formal assessment completed to explain why this was in the person's best interest and how exactly the medicines were to be given covertly. The person's records showed that an instruction to complete an assessment under the Mental Capacity Act 2005 had been provided by the Dementia Nurse Specialist on 21 January 2016. This had been not been completed by the registered manager or staff at the service at the time of the inspection and remained outstanding.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). On Kingfisher 2 unit, one person was lying in their bed surrounded by barriers of some form on all sides and so were being restrained in their bed. There was no assessment on the person's file to indicate that this was intended to be in the person's best interest and no related mental capacity assessment was in place. The registered manager told us they were unaware of the situation and that this had been implemented by staff. This meant that important decisions about people's health and welfare were being taken by staff who were not appropriately authorised to do so and that the registered manager was not aware of how people's care and treatment was being provided.

People's rights had not been safeguarded. One person stated clearly on more than one occasion that they did not wish to stay in the service and they wanted to leave. They were unable to do this as there were security systems on the doors to prevent people leaving the premises unsupported for their safety. The registered manager confirmed that there was no application for legal authorisation in place in relation to this person being restrained within the premises. The registered manager told us that 66 people living in the service required to have an application for a DoLS authorisation in place but that these had not been made. This demonstrated that the registered manager had not acted within the law and showed they had limited knowledge and understanding of their responsibilities. Subsequent to the inspection, we requested further clarity on this from the registered provider who advised that the number of people living in the service who currently required a DoLS referral was 50 and that these were now being made.

Records provided by the registered manager, and confirmed to us by the registered manager as an accurate and up-to-date record of staff training in the service, showed that the registered manager and most of the

staff team had not completed training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

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

Staff were not suitably trained and supported to provide people with the care they needed. The manager provided us with a record which they confirmed was accurate and up to date in regards to staff training in the service. This record showed that all staff had not received training or updates in a number of important areas such as safeguarding people, moving and handling, dementia awareness and dignity in care. We spoke with six staff regarding this and reviewed six staff records. Some staff confirmed they had had an induction to the service and initial training. Other staff were unable to clarify whether they had received an induction or training when they first started working in the service. Records confirmed this. There was no evidence of ongoing suitable supervision or appraisal to give staff the opportunity to discuss their development needs and to receive structured feedback on their practice. These shortfalls, along with our discussions with staff and observation of poor staff practice demonstrated that all staff were not provided with suitable induction, training, supervision and support to enable them to meet people's needs competently and effectively.

People experienced poor care outcomes because staff did not have the skills, knowledge or competence to care for them effectively. A relative said, "I am not sure staff are trained properly. They try to clean [person] while they are in held up in the hoist rather than rolling [person] from side to side on the bed as they do in the hospital." We saw that staff were not skilled and adept in engaging people with dementia associated needs, such as while supporting people to eat or trying to diffuse situations where people were distressed, to provide them with the necessary care and support. It showed that staff did not use the learning from their completed training effectively in their day to day practice such as in safe moving and handling of people, or had not received suitable training, ongoing observation and assessment of their practice to make sure they were competent for their role and that their competence was maintained so as to meet people's needs.

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

People experienced differing levels of care in relation to their nutrition and hydration needs and improvements were needed. One person's malnutrition screening tool identified they were at risk. The person's records showed they had lost almost 6 kilograms in weight when they were last weighed in December 2015. There was no evidence that the person had been weighed since then in line with level of risk to minimise risks to their health. This was discussed with the registered nurse at the time of the inspection. They were not aware of the weight loss but confirmed that steps would be put in place to follow this up.

Mealtimes weren't always an enjoyable experience for people and they did not always get the support they needed to eat and drink enough to meet their needs. On Maple unit we saw that people were able to choose from two meals for their lunch and people's preferences were respected and provided for. One person said, "The food is lovely, especially the puddings", and a relative felt that their family member had gained weight while living in the service. One person told us that the service supported their individual dietary needs well to meet a specific healthcare requirement.

This was not the experience of people on Kingfisher 1 at breakfast time. We saw that only one member of staff was available in the dining room at times where 13 people with clear needs associated with dementia were seated. People received limited attention and support to eat and drink and in many cases food was

spilt or not eaten. While a choice of meal was available at lunchtime on Kingfisher 1, people were not supported to make a choice and were not told what the available meal choices were. Most people's meal was put in front of them by the care staff without any interaction or explanation to the person of what meal they were being given to encourage their interest and tempt their appetite. People were given their pudding, which was meant to be served warm, before they had completed their main meal. This meant that people either had to have their pudding cold which may not be enjoyable or not finish their main meal before eating their dessert and miss out on nutritional intake. This could also cause confusion and distress for those people living with dementia who struggle with multiple options at any given time. One person said, "I haven't had a good meal since I've been here. A meal that I've enjoyed." Another person said, "I don't like it. Its stuff I don't like. We have too many chips."

We saw a member of the social activity staff support a person with their lunchtime meal on Kingfisher 1 and this was done with explanation, encouragement and at the person's own pace. However in most cases, there was limited interaction by the care staff with people during the mealtimes observed and where there were interactions, these were often negative in nature. One staff member on Kingfisher 1 unit repeatedly attempted to put a napkin over a person and the person repeatedly push it away. The staff member did not speak to the person during this exchange. The staff member assisted the person with their meal and pushed the food near the person's mouth and the person pushed it away. The staff member did not speak with the person to explain what the food was to engage or encourage the person to eat their meal.

On the first day of our inspection every person was given a dark coloured drink with their lunch and not offered any choice. We later queried this with staff who could not give a clear explanation for this practice. On the second day we saw that everybody was given an orange coloured drink instead. On the third day we saw one person ask for a cup of tea at 10.55am in a dining room area with ready access to tea making facilities. A staff member gave them a cold drink and, until we intervened, told them they would have to wait until the morning tea round was served at 11am before they could have a cup of tea. This meant staff did not respond to people as individuals and that the care provided was task led rather than person centred.

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

The registered provider had arranged for a GP and a consultant geriatrician to visit the service weekly to advise staff on supporting people's healthcare needs. We spoke with a healthcare professional who advised us that the registered manager and the nurses tried to do what was asked of them. Another professional advised that the service was improving people's health and reducing the number of infections or pressure ulcers people acquired. Relatives told us that the service contacted health professionals appropriately for their family members and kept them updated as to the person's condition.

Inadequate

# Is the service caring?

## Our findings

Some relatives spoke highly of some of the staff working at Forest Place and their caring approach. One relative said, "People like these carers. Simply they're magic. Obviously, at times, they can't be everywhere, but they're helpful. They're very, very helpful." One person said the service is 'nice' and that, "The nurses are lovely and care for me well." Another person said, "Some staff are not doing their job of caring. Others are wonderful, caring and communicative."

Our findings however, in terms of how staff were supported to ensure people's well-being, their observed approach to people and all support functions including care records and management support, did not indicate a caring service. We saw that staff were not skilled and competent in engaging people, especially those with dementia associated needs, so as to provide them with the necessary care and emotional support. Observations showed that staff did not have an understanding of how to engage people in meaningful conversation to enrich people's social and emotional experiences or to communicate with people in a way that helped them to understand and show preferences, such as what to eat and drink. The organisation of people's care and the arrangements to ensure enough staff to support it was not considerate and compassionate.

Some staff did not act in a compassionate way towards the people they supported. One person repeatedly called out loudly, "I do not want to sit in this dirty chair. I want to sit in my own chair." The person was sitting in a wheelchair clearly labelled with another person's name, which staff later confirmed. Staff present did not acknowledge the person's conversation and simply ignored them and their request. We saw that people became distressed while being transferred using equipment and people showed this verbally by shouting out, where previously they had been calm. Staff did not interact and communicate with them to explain and reassure them during these procedures. Some of the many people cared for in their bedrooms were clearly distressed at times. Except when tasks were to be performed, there were generally no staff nearby to offer them human contact and some relief from the isolation. During lunchtime on Kingfisher 1 we saw that two people shouted loudly at each other and used inappropriate words over a 25 minute period. None of the staff present took any action to try to distract the people, diffuse their levels of anxiety or distress or that of other people nearby who were having their meal. This meant that people did not get the comfort or reassurance needed to ensure their well-being.

Care was not dignified or person centred. We saw a wardrobe in one person's bedroom with a label advising that there were spare clothes for use if people needed them. Staff could not confirm if the person whose bedroom it was had been asked about storing communal items there or if the person could agree to this. A staff member confirmed that they were clothes of deceased people and were for use of any person in the service who staff identified needed them. We raised this with the provider's representative who confirmed this was not acceptable. The label had been removed by the following day; however the wardrobe still contained boxes of clothes labelled such as 'ladies underwear'.

We checked the sheets on one person's bed that had already been made. We found that the bedsheet on the bed was wet and that a small disposable mat was placed on top to cover the wet area rather than the

bed be changed and fitted with clean, dry bedlinen. Linen on some beds were missing or stained and dirty. A staff member told us that there was not enough spare linen to allow them to provide people with clean bedlinen as the ten spare sets went to another unit where, "people got very messy". The registered manager and the provider's representative told us this was not accurate and that staff had access to ample bedlinen but had not gone to get it. A relative told us they brought in their own bedlinen for their family member as that provided by the service was poor in quality and cleanliness. The beds we looked at were fitted with clean linen by the second day of the inspection.

A professional told us that there had been an increase in inappropriate referrals to hospitals where people were on an end of life pathway and that there was a reluctance in the service to deal with complex medical issues. A care plan for a person who had been assessed as approaching the end of their life and associated records relating to their end of life care needs were either not up-to-date or not recorded. There was limited information on whether the person may have months, weeks or days to live in order to aid care planning arrangements and discussions with the person and those acting on their behalf. For example, the care plan provided little or no information detailing the person's pain management arrangements and the care to be provided so as to provide comfort to the person. No information was recorded explaining what treatment should be provided for their health if they were no longer able to make decisions for themselves.(Advanced Directive). This demonstrated that people and those acting on their behalf were not involved in the assessment and planning for their end of life care or supported to make choices and decisions about their preferred options. This meant that people's 'end of life' wishes were not recorded in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE].

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

Inadequate

# Is the service responsive?

## Our findings

Assessments of people's needs were not always comprehensive to ensure the service could meet their needs. One person's records showed that they had been unable to continue living at their previous care home as that service was unable to support the person's anxious and distressed behaviours associated with dementia and mental health needs. The assessment completed by the registered manager of this service prior to the person's admission made no reference to these behaviours. This does not comply with the provider's written policy on 'service user care plans' which states that a thorough assessment would be completed that would cover all aspects of the prospective service user's needs, abilities and aspirations. This meant that all available information was not demonstrated as considered to assess if the service could meet the person's individual needs and provide a basis to guide staff to implement a person centred plan of care.

Some relatives told us that their family members were well cared for in the service. The registered provider's Statement of Purpose informs people, "We are specialised in Dementia Care, Palliative (End of Life) Care and Respite Care", however this was not supported in the care records or in our observations of the care some people experienced.

We were not assured that people were receiving the care and support when they needed it as care was either not given consistently and in a person centred way and/or inconsistently recorded or not at all. The registered manager told us that only one person using the service had a pressure ulcer at the time of our inspection. From the records we reviewed we identified that at least three people using the service had pressure ulcers which were confirmed by the nursing staff on the different units. It was not clear if other people had pressure ulcers as this information was not clear in their care plans. Body map records were muddled and had numerous entries, some of which were dated and others that were not, making it impossible to judge which were current and needing care and treatment. A body map chart should record the site of an individual injury or wound with the date it occurred and the date that it was considered as healed so there was a clear and current record for each individual person.

The records of routine care interventions for a person who was cared for in bed on Kingfisher 2 unit stated that the person had been given a drink at 11am. Two inspectors were in the area at this time and no staff entered the corridor, or the person's bedroom around that time, so the record could not be relied upon as accurate. The person was unable to ask for support and had no way of summoning assistance. We saw that one staff member did attend the person's bedroom at 11.15 and recorded that the person refused a drink. As they left the area the staff member told us that the person needed changing and the odour in the room confirmed this. The person required two staff to support their personal care needs. When we checked later we found that the person had not been given any support. As the person was unable to tell us their experience we confirmed this lack of responsive care in the records and with the member of staff who told us they had forgotten to tell other staff that the person needed care so they could do that task. It took 40 minutes for the person to receive the required support. As there were no staff at the end of Kingfisher 2 unit where the person's bedroom was and as staff told us routine checks of people nursed in bed were completed two hourly, we were not reassured when the person would have received the care they needed

had we not intervened.

Personalised care plans were not always in place in a timely way or were not sufficiently detailed to support responsive and consistent care for people living in the service. One person had complex needs especially in relation to behaviours associated with dementia and mental health needs, however 15 days after admission their care plan had still not been written. Staff confirmed this, which meant that staff did not have clear written guidance on how to respond to the person's individual needs and provide person centred care. At the time of our inspection we identified one person admitted in early December 2015 who did not have a care plan in place for identified areas of assessed needs. These included diabetes, catheter care, behaviours associated with dementia, eating and drinking, pressure area care, mobility and medicines. This impacted on the person for example by placing them at greater risk of developing pressure ulcers as staff did not know the setting for the person's pressure relieving mattress when it showed a fault or whether the person actually had a pressure ulcer. The lack of the care plan was recorded as having been identified by a visiting social worker on 28 January 2016, but the care plan was still not completed or available when requested during our inspection. The lack of care plans also meant that people's specific needs were not identified so that actions could be planned to enable these to be met, particularly where people were unable to communicate their needs verbally.

Care was not always provided to people in line with their individual plan of care. A care plan for one person's complex behavioural needs was in place however it did not provide staff with guidance on known triggers or distraction methods to support the person. While the care plan required that all incidents were to be recorded the last entry on the behaviour observation charts was dated 9 December 2015. Daily records showed a number of incidents throughout December 2015 and January 2016, some of which impacted on other people including causing injury to another person living in the service. This showed that the lack of detail in the person's record had impacted on people's wellbeing and safety.

The lack of recording on the behavioural observation charts did not support effective monitoring to enable staff to review the planned care strategies and update them as needed. Some people were at risk of dehydration and their fluid intake was to be monitored and recorded to ensure their care needs were met and enable changes to be made as their condition indicated. We found that there were gaps in the recordings where people should have been provided with regular drinks. This suggested that either the drinks were not provided or that the records were not accurate. It meant that people's care could not be monitored easily to identify if changes were required to ensure that the care provided was responsive to meet people's changing needs.

Some records showed that people and/or their relatives were involved in the person's plan of care initially and completed a document called 'All about me'. Care records were not regularly reviewed so there was little evidence to show that people were involved in making decisions about their on-going care needs. One person's nationality was recorded as one type of faith while their religion was recorded as another type of faith. This showed that people's personal information was not always treated respectfully and used to support care that responded to their individual needs..

While many people were unable to tell us their view, we observed that people experienced limited opportunities for meaningful social interaction and activities responsive to their needs. The service employed three people to assist staff with social activities. On one day we saw that a group of people from different units were involved in a weekly singing activity on Kingfisher 1 unit which was led by an external volunteer. On Kingfisher 2 unit we saw a crossword activity taking place with a group of people, none of whom could see the puzzle itself and all but one of whom had their eyes closed or were not attending to the calling out of the clues and the number of blank spaces remaining to complete the word. The activity was

clearly not interesting to people or suitable to meet their needs and abilities.

We saw numerous occasions where people just sat in communal rooms or were in individual bedrooms for extended periods of time with no social stimulation, no music or entertainment and/or while staff sat in the room and completed records. On one occasion we noted that the only activity or interactions of any kind that occurred for people in a communal room over a one hour and forty five minute period was that one person had their nails painted.

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

Most relatives told us they felt welcome in the service and visited at different times. Another relative felt uncomfortable visiting the service and told us they did not feel welcomed by staff because they queried the lack of actions by staff and the level of care provided to their family member. The person told us that they had raised their complaints verbally but were now going to raise their complaint formally with the service.

People had access to information on the registered provider's complaints procedure as this was displayed in the different units in the service. It advised people of timescales within which response and actions would be implemented so people knew what to expect. Information on the complaints and concerns procedure was also included in the registered provider's Statement of Purpose and Service User Guide which was made available to people on admission to the service. The registered manager told us they had received numerous compliments about the service.

Improvements were needed to the management of complaints and concerns raised within the service. The registered manager told us that two formal complaints had been received and investigated. Records of both complaints showed that they had not been responded to promptly by the registered manager. Action satisfactory to the complainant was taken in one case. Records showed that the second complaint had been referred to the Local Government Ombudsman as the complainant remained dissatisfied with the provider's response.

The registered provider told us in September 2015 that all complaints, both formal and verbal, were recorded within the service to enable their effective management to support improvements, to allow monitoring for trends and to identify staff training needs. We found however at this inspection that all complaints had not been recorded. A relative told us of a complaint they had raised which had been responded to and suitable action taken. Minutes of a relatives meeting showed that complaints and concerns had been raised such as insufficient drinks being provided for people and the level of staff understanding or confidence to respond to people's communications. Records showed the concern regarding communication had been discussed with staff in a staff meeting. The registered manager confirmed these had not been included within the complaints records in line with the registered provider's policy so that demonstrated actions could be planned and improvements made.

Inadequate

# Is the service well-led?

## Our findings

The service was not well led. The registered manager told us they were unaware of the legal responsibilities of their role such as the requirement to notify the Commission when a person died or when authorisation was received to deprive a person of their liberty. However, we had sent written information to the registered manager and the registered provider in September 2015 advising them of their legal responsibility in relation to notifications including in relation to deaths of people using the service. The registered manager and registered provider had failed to notify us of any deaths in the service. Subsequent to the inspection and at our formal request the registered provider informed us of 57 deaths in the service since 01 January 2015 and told us they were submitting the retrospective notifications. We will review the information to check that this is a reasonable outcome for a service that provides people with end of life care.

This is a breach of Regulation 16 of the Health and Social Care Act 2009 (Registration) Regulations 2014.

While a registered manager was in post, there was a demonstrated lack of oversight and leadership in the service. The current manager had been registered in the post since January 2015. A second manager who had also been registered at the service had left in June 2015. The current registered manager told us they had not had sufficient administrative support to manage the service and had also regularly covered nursing shifts as part of the staffing team. All staff we spoke with told us that they found the manager approachable and supportive and confirmed that the manager worked with them on the shift when there were staff shortages, especially of qualified nurses.

Relatives expressed varying views as to the management of the service. Two visitors told us the registered manager was "very nice". One relative however told us, "The weakness here is the manager, they are not able for the staff and deal with one issue or one person but not the problems overall. Nothing is planned, organised or followed up." Another relative told us that they were able to approach the registered manager with concerns but that, "The staff run the home, not the manager".

We found that the registered manager was unaware of events pertinent to the care of people in the service, for example, how many people in the service currently had pressure ulcers. This indicated a lack of role clarity within the staff team leading to poor communication systems. The lack of accountability and leadership within the staff team was confirmed by the provider's representative. The registered provider's quality care manager had identified and advised the registered provider of the lack of leadership and accountability in the service in December 2015 and suggested the need for a clinical lead or deputy manager to support the registered manager. The provider's representative told us this post was being recruited to and an appointment was imminent.

The registered manager and the registered provider could not demonstrate that the service was managed and operated to ensure the safety and benefit of people living and working there. Staff were not suitably trained and their practice was not supervised to ensure competence, safe care and the right values and behaviours towards people. Required records were not always in place to support good care and effective management, or the accuracy of records could not always be relied upon. There were no systems in place to

check the accuracy of the settings of pressure relieving mattresses or to monitor people's fluid intake and repositioning charts to ensure they supported safe care. The registered manager confirmed that the infection control audit dated July 2015 was the most recent of the monthly audits completed apart from monthly medication audits.

Where checks were in place they did not identify concerns we found or did not result in action being taken to improve the service. We saw that medication audits and assessments of staff competence to manage medicines were completed and had not identified any concerns for corrective action. An audit of 15 care plans was completed in December 2015. This identified gaps in care records including missing pre-admission assessments, care plans and deprivation of liberty authorisation applications. However, action had not been taken in response to the failings identified. While there were reporting systems in place for maintenance issues, these were not being used by staff to ensure improvements for people, for example the broken bed and the potential falls risk from the unsafe carpet we identified.

There was no demonstrated internal system to monitor and analyse deaths, accidents and falls to consider any trends so that actions could be implemented to improve people's experience. We asked the registered manager on four occasions during our inspection for data relating to these areas so that we could view their analysis and any improvement actions planned or implemented. This was not provided. Subsequent to the inspection, information was provided to us regarding the deaths in the service, following a formal written request to the registered provider.

The registered provider's Quality Assurance and Management Policy, dated September 2015, stated that a programme of auditing was in place, with monthly external visits by the registered provider's representative and that a monthly quality report to include the information from these audits was submitted to the head office. The registered provider's representative told us that while the quality care manager had visited the service for meetings in October and December 2015, full external monitoring of the service had not been completed since April 2015 due to an absence of a member of the quality team. The provider's representative could not demonstrate that this lack of information and data relating to their service had been identified and suitable measures put in place to address it. The registered provider had not reassured themselves of the safety and quality of the service that they provide and taken timely action to identify and address the failings within the service. It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner.

People living in the service, their relatives and staff working there had opportunity to express their views about the service. Records showed that 30 per cent of relatives and 29 percent each of people living and working in the service had participated in a satisfaction survey in 2015. Many of the questions scored positively including cleanliness, consultation on care plans, friendliness and courtesy of staff and laundry services. Décor, furnishings and appearance of the premises scored poorly for relatives and staff while people living in the service were less satisfied with choices in daily routines, approach to their rights including confidentiality and the availability of social activities and bedtime snacks. Only three people knew how to complain. Staff were satisfied for example the home's ability to cater for people's care and assistance to support people to eat and drink with dignity. Staff comments noted a lack of opportunity for career progression, pre-training preparation leading to poor attendance and the need to recruit more experienced staff. The provider's representative told us of major plans to develop and refurbish the premises. No action plan had been produced in relation to other issues raised so this could be shared with the people who had completed the survey to demonstrate that their views were listened to and used to improve the quality of the service they experienced. No clear explanation for this was provided by the provider's representative or the registered manager.

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

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered provider had not ensured that people's rights were safeguarded. This was in breach of Regulation 11(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>We found that the registered provider had not ensured that systems and processes were established and operated effectively so that people were protected from abuse. This was in breach of Regulation 13(1) and(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>People who use services and others were not protected against the risks associated with unsafe or unsuitable premises and equipment because of inadequate maintenance and cleanliness and failure to use equipment properly. This was in breach of Regulation 15 (1) (a)(c)(d)and (e) |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The registered provider had not ensured that staff recruitment procedures were robust to safeguard people using the service. This was in breach of Regulation 19(1), (2) and 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered provider had not ensured that there were sufficient numbers of staff deployed so as to enable them to meet people's care and treatment needs and that staff had received suitable training, ongoing supervision and appraisal to make sure they were competent for their role and that their competence was maintained This was in breach of Regulation 18(1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered provider had not ensured that people's care was planned for so that staff had information to guide them on how each person's needs and preferences were to be met and ensured that the care provided was person centred and met the person's identified needs.This was in breach of Regulation 9(1) (2)and (3)(a)(b)(d) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

Notice of Decision

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider had not protected people against the risks of inappropriate care and treatment. This was in breach of Regulation 12(1) and (2)(a)(b) (c) (d) (e) (g) (f) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

Notice of Decision

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider had not operated effective systems to protect people against the risks of inappropriate or unsafe care as robust arrangements were not in place to assess and monitor the quality of the service provided. This was in breach of Regulation 17(1) and (2)(a),(b) (c) (d) (e) and (f) of the Health and Social Care Act |

2008 (Regulated Activities) Regulations 2014.

**The enforcement action we took:**

Notice of Decision