London and Manchester Healthcare (Darnton) Ltd

Darnton House Nursing Home

Inspection report

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Date of inspection visit: 16 and 17 November 2015
Date of publication: 12/02/2016

Ratings

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

Overall summary

This inspection was carried out over two days on the 16 and 17 November 2015. Our visit on 16 November 2015 was unannaounced.

This was the service's first inspection following registering with the Care Quality Commission (CQC) in March 2015.

Darnton House Nursing Home provides accommodation for up to 96 adults who require nursing care. It is a privately owned service. The service is located in its own grounds close to a local hospital.

The ground floor accommodates 32 people who are living with dementia. The 1st Floor accommodates 32 people with physical care needs. The top floor accommodates

Summary of findings

up to 32 people who are medically fit and transitioning back into the community for care and support as needed. This is a joint project between the service and Tameside Hospital Foundation Trust.

At the time of our inspection, 18 people lived in the service and a further 18 were living there temporarily before moving back into the community.

Prior to the inspection the Care Quality Commission (CQC) received a number of serious concerns relating to medicines management, appropriate care and support of service users and staff suitability.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found breaches of Regulations 9, 11, 12, 13, 14, 15, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager of the home at the time of our inspection. 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.

The service was not well led. The provider did not have effective systems in place to identify the risks to people's health, welfare and safety and failed to provide appropriate care to maintain their safety.

People who lived in the service did not consistently receive their medicines in a safe manner that met their individual needs. Arrangements to ensure that people received the correct medicines were not in place. The storage, administration and timing of medicines were unsafe and did not meet individual needs. We saw that there were not clear instructions available for staff to give medicines. Where instructions were available, these had not been correctly followed. This placed people at risk of harm.

The service was not consistently respecting and involving people who use services in the care, they received. For example, the care plans reviewed during the inspection did not involve the person or their relative when they were written and the person's views, choices and personal preferences were not reflected.

People had no input into the planning of menus or activities which meant that people's preferences, choices and personal opinions had not be sought or considered as part their right to participate in making decisions about their daily lifestyles and freedom of choice.

The service was not meeting its obligation under the Mental Capacity Act (2005) for people who may lack capacity to make decisions. For example, people's mental capacity was not assessed and decisions were made that did not support people's rights. Such decisions that people may find difficult to make for themselves could be small decisions – such as what clothes to wear – or major decisions as where to live. In some cases, people can lack capacity to consent to particular treatment or care that is recognised by others as being in their best interests, or which will protect them from harm. The Mental Capacity Act (2005) has been introduced as extra safeguards, in law, to protect people's rights and make sure that the care or treatment they receive is in their best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that where required, not all the necessary DoLS applications had been made. The manager was unable to determine what applications had been made or if they had been progressed. The deprivation of liberty safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty whilst living in a care home. Lack of appropriate DoLS applications and authorisations being made could mean that restrictions had been placed on a person's liberty that are not in their own best interests to protect them from harm.

We saw that people's health care needs were not accurately assessed and that risks such as poor nutrition were not always recognised. People's care was not planned or delivered consistently. In some cases, this put people at risk and meant they were not having their individual care needs met.

Records regarding care delivery were not checked to ensure accuracy or that they were up to date leaving people at risk of not having their current individual needs monitored or met.

The provider's staff recruitment practices were not in keeping with their own policy. We saw that staff had not all received appropriate checks before they started

Summary of findings

working in the service. References were not validated to make sure they were genuine before staff started working in the service. Lack of appropriate and safe pre-employment checks being conducted before someone started working in the service placed both people using the service and other staff at risk of unsuitable people being employed.

We saw that the management of nutrition was not sufficient to make sure that people's nutritional needs were identified in a timely manner and that they were provided with diets that met their needs.

The reporting and addressing of safeguarding incidents was not sufficient for the service to be aware of what concerns were in place nor, what action they needed to take. Safeguarding concerns were not recognised or addressed.

The environment was well decorated and furnished to a high standard, however it had not been adapted to meet people's needs and in some instances was not suitable for the people living there. For example, decoration in parts of the home was not appropriate for people living with dementia and lighting in certain parts of the home was poor, especially for people with restricted sight.

Feedback from people living in the service and their families was complimentary regarding staff and the care that they received.

The overall rating for this service was 'Inadequate' and the service is therefore in 'Special Measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People who used the service were being put at risk because medication was not given safely.

The service did not have sufficient arrangements in place to recognise risks to people's health and welfare. There was insufficient arrangements to deal with risks and to make sure that the service took appropriate action to reduce any risks.

Staff were not always appropriately checked for their suitability before they started working in the service.

Is the service effective?

Inadequate

The service was not effective.

We found that care plans did not accurately reflect people's individual health and social care needs. As a result, people did not always receive care that met their personal needs.

Staff did not have up-to-date training and ongoing planned supervision.

People who had fluctuating capacity and were less able to make a decision did not have arrangements in place to maintain their rights.

Is the service caring?

Inadequate

The service was not always caring.

We found that staff's approach to people did not always take their individual needs into account.

Although we saw some positive interaction between people and staff we found people's choice and autonomy was not consistently promoted.

There was an institutional approach to care that did not take into account peoples diverse needs or encourage them to be as independent as possible.

People who lived in the service thought staff were kind and caring.

Is the service responsive?

Inadequate

The service was not responsive.

We saw that care records did not always reflect up-to-date information for staff to be able to meet people's needs. Information about people's preferences, choices and risks to their care were not recorded. As a result, some of the people had not received care that met their individual needs.

The service did not manage complaints that had been raised.

There were not enough meaningful activities for people to participate in as groups to meet their social needs; so some people living at the home told us they felt that there was little to do.

Summary of findings

Is the service well-led?

Inadequate 

The service is not well led.

No registered manager was in post at the time of inspection.

People were put at risk because systems for monitoring quality were not effective.

The culture of the service was not centered on the person but was more around the tasks that the staff had to achieve each day. This approach did not support people's individual needs.

Darnton House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 November 2015 and was unannounced. The inspection team consisted of four adult social care inspectors on the 16 November 2015 and two adult social care inspectors on 17 November 2015. During the inspection, we spoke with nine people living at the service, five relatives, ten staff, the manager and two of the Company's Directors. We also spoke with five external professionals, including doctors, before, during and after the inspection. The views of all the people we consulted with are reflected in this report.

On this occasion we did not ask the provider to complete a provider information return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make. Prior to our inspection we looked at all the data and information we held about this service and noted that a number of concerns had been highlighted. We had also received concerning information from the Local Authority Commissioners and Clinical Commissioning Group that also used the services of this particular provider.

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 observed care and support in communal areas and looked at the kitchen, laundry and the majority of the bedrooms. We reviewed a range of records about people's care and how the home was managed. We looked at some aspects of care for thirteen people in total this included looking at care records, risk assessments, food and fluid records, turn charts, daily records, professional visits records, diary records, menus, medication administration records and care plans.

We looked at a variety of staff records including training, induction and supervision for all staff and recruitment records for ten staff employed at the home. We looked at other records including quality assurance audits that were available at the inspection.

Inadequate

Is the service safe?

Our findings

People we spoke with informed us that they were happy living or staying in the service; comments included "it's a beautiful place", "I am very comfortable the staff are really kind and helpful" and "Yes, I feel safe, I think they are always trying to make sure I'm looked after properly. So far, it has been a pleasure to stay here."

Relatives told us, "I can't fault anything I'm very happy [name of person] is staying here". Those relatives we spoke with told us they thought that staff did care for their relative.

Prior to our inspection, we received concerns related to unsafe care. These included information from relatives, Local Authority Safeguarding Team, Health service provision and from anonymous concerns raised by staff. The information we received covered a variety of concerns including not managing wounds, incorrect medicines, where people living with dementia had behaviour that may challenge, this was not managed well and poor medicines management.

At the inspection we were given a file that the manager informed us contained all the safeguarding notifications records, that they were aware of, that had been made to the Care Quality Commission (CQC). We saw that there was no records of the service's own investigations or lessons learnt in relation to safeguarding alerts. We spoke with the manager and the provider. They were unable to state how many safeguarding alerts had been received in total nor demonstrate that the concerns they had received were addressed appropriately in order to make sure people living in the service were protected from a recurrence of the concerns. A copy of the local authority's inter agency safeguarding guidelines (April 2015) was displayed on each floor of the home to which staff had access.

Discussions with staff told us that they were aware of how to inform the manager of safeguarding issues but not all had received up-to-date safeguarding training. The actions that the staff told us they would take if an alert was raised with them were inconsistent and, in at least two cases, would have interfered with any full investigation. The training record provided by the manager indicated that 31 staff had completed safeguarding vulnerable adults training.

Our inspection identified four further safeguarding concerns that the service had failed to recognise or action. These included medicines not being given, not recognising risks related to falls and unexplained bruising. We requested that the service made safeguarding referrals for the four people. Following our inspection, we received confirmation that the appropriate referrals for safeguarding investigations had been undertaken.

None of the safeguardings had been subject to the service's own investigation once external parties had completed theirs.

In discussion with the staff and on reviewing training records, staff were unclear on what a whistleblowing complaint was and the complaints policy did not reference whistleblowing complaints made by staff or how they would be dealt with.

Overall, there have been a significant number of concerns raised regarding care in the service that have been upheld as neglect. As a result, stakeholders had made a decision not to admit people into the service until the quality of the service had improved.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not have an effective system in place that recognised potential abuse or took appropriate action taken when concerns were identified.

There were no infection control arrangements available in the service and the infection control codes needed in order to monitor infection control correctly were not being followed.

Furniture was of a good quality, but the appropriateness of the layout of the building, ifs fixtures and fittings and the potential risks they presented to people had not been recognised. There were a number of sculptures and tables with sharp corners throughout the building. Risk assessments as to the suitability of the furniture had not been undertaken.

We looked at how the service managed medications and found that people were not getting their medications, as they should in a safe way.

Inadequate

Is the service safe?

We saw from the records that five people had not received their medicines for two or more days. There was no explanation available as to why the people had not received their medicines in accordance with the prescription.

Where medicines were given, these were not always given accurately, as an example, we saw that one person received antibiotic therapy that commenced with 200mls and the person was given 140 mls. Staff then recorded the course as completed. The person should have in fact received the entire 200mls before this was stopped.

We saw that medicines were not given at the correct times, as an example, medicines to be given before food and medicines to be with food were given at the same time. On all occasions, these medicines were given with food.

We saw that nursing staff were signing for items such as food thickener, supplementary drinks and creams that they did not administer, but was given by care staff. Additionally we observed unsafe practice from nursing staff including signing for medicines before they were given.

The service operated two different medication administration processes. The first two floors operated a community care based system and the top floor a hospital-based system. There were policies and procedures in place for the two lower floors and none available for the top floor. The policies and procedures for the first two floors did not follow the guidance in place from NICE (National Institute for Clinical Excellence). Staff on the top floor reported that they had not received training in the medication administration process and that they were unfamiliar with how this worked. The service did not have any arrangements in place to make sure that it's staff gave medicines correctly on the top floor. We were informed that the pharmacy team from the adjacent hospital checked daily that medicines were given correctly. We looked at these records and found no evidence that medicines were checked as given correctly by the staff. We saw concerns with medicines such as unclear records for discontinued medicines that had not been recognised by the pharmacy team assisting with medicines. We discussed this matter with the provider and a representative of the hospital. We were assured by both that this would be addressed.

We looked at how the service managed external preparations such as creams. There were no records available in the service that fully described the use of creams. One record on the top floor included references such as 'apply to feet'. It was not specific about the area of the feet, how thickly or thinly the cream was to be applied. As such, instructions as to the appropriate use of the cream were either not available or incomplete. Additionally, there were no arrangements in place in the service to monitor that creams had been correctly applied. We saw in some areas of the service creams were left unsecured in people's bedrooms and were not kept safely.

We looked at how medicines that were "prescribed as needed" (PRN) or of a variable dose were managed. Such prescribed PRN medication could be paracetamol, prescribed to be given only when needed. There was limited information available in the service for people who had medication prescribed "as needed" (PRN). We saw that not all medicines 'as needed' or of a variable dose had instructions available to staff as to how, when or in what circumstances they were to be given. As such, staff did not have access to the instructions they required to make sure they gave PRN or variable dose medication safely .

Handwritten instructions on medication records for people new into the service were not checked as accurate or signed. The service did not check on admission if the medicines supplied were current medicines, as the service's policy did not instruct them to do so.

We were informed by the provider, manager and staff that competency assessments for staff to determine if they could give out medicines safely were not in place. As such, the service could not be assured that staff had the skills and competency to give out medicines safely.

On the top floor, we were told that there were no arrangements available for people to self-medicate, despite the fact that many were returning to their own homes or into the community. We saw one person staying on the top floor was trying to use an empty inhaler and was breathless. This person did require the opportunity to self-medicate but as there were no arrangements in place to assist people to manage any of their medicines this person was placed at risk. We also saw that this person did not have direct access to the call bell system to request assistance with their medication which placed them further at risk.

On the other two floors, we found one person was managing their own medicines however; the arrangements in place were not safe. There were no checks that the

Is the service safe?

person was taking their medicines correctly, no arrangements to review their ability and no arrangements to ensure that their medicines were stored correctly. It is always good practice in promoting independence for people that they manage as many of their own medicines as possible however, this must be undertaken safely.

A review of care records showed that the service did not always have nutritional risk assessments that monitored individual weight loss or gain. Where they were in place, they were not kept up to date. We did see that there had been improvements in making appropriate referrals to nutritionalists. However, where the risk assessment described a certain level of action, such as, 'weigh weekly' this was not carried out. When potential weight loss was identified limited action was recorded as being taken.

We looked at accident records and noted that one person fell out of bed despite bedrails being on the bed and risk assessed as appropriate. No investigation had been undertaken to determine what the cause of the fall was or what actions needed to be taken to reduce the risk. As a result, the risk continued and the fall risk assessment and care records were not updated. A further person fell on seven different occasions over a two months period and the risk assessment had not been updated and no actions recorded as to what the service had done to reduce the risks. Following our inspection, both matters were referred to social services for review as potential investigation under the local authority's safeguarding protocols.

Risk assessments for the development of pressure ulcers were undertaken but not reflected in care records. When wounds were identified, the treatments in place to prevent further risks were not clear. The monitoring of positional changes to assist in preventing further pressure ulcers were not always in place. A recent investigation had up held that the service had failed to protect a service user from the prevention of pressure ulcers. There were inconsistent care plans in place to reduce the risks of further damage or promote healing. Some of these contained instructions that were not followed, whilst others did not refer to wounds or pressure ulcers even when dressings for wounds were in place.

We asked for, but were not shown a fire risk assessment. One had been completed prior to the opening of the service but had not been updated. Following our inspection, we received a copy of the updated fire risk assessment undertaken on the day after our inspection. Lack of an up-to-date fire risk assessment being carried out and available placed people using the service, staff and visitors at risk.

People's records showed that moving and handling risk assessments were not updated and did not contain clear information that would inform staff how to appropriately move and handle people safely. Lack of appropriate and up-to-date moving and handling risk assessments being in place and available placed both people using the service and staff at risk.

Where risks to people were identified these were not reflected in the care records. As an example, two people were detailed by the manager and staff as requiring input for behavioural needs. Some people using the service may have behaviour that can be challenging or, at times, place other service users and staff at risk. Neither person had risk assessments in place to manage the risk to themselves and others, neither had care plans in place to assist staff to reduce and manage any potential risks. This meant that people living in the service and staff were placed at risk of potential harm.

This was a breach of Regulation 12 of the Health, Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was failing to ensure that care, and treatment was provided in a safe way.

We reviewed the records regarding staff recruitment and spoke to staff about their recruitment. We saw that not all staff were checked prior to their employment as suitable to work in the service. Additionally, not all staff files had a record of their initial interview and a copy of their application available. This meant that evidence was not available to demonstrate that a fair and robust recruitment process had been adopted and used for the recruitment of staff.

Two references were not consistently available and these were not checked as valid references. The service's own policy stated that two references are needed; one of which must be from the person's last employer. In at least two files we saw that no references from the previous employer were available. The service had not met it's own policy and procedure in making sure staff were safely recruited.

Where staff did have gaps in their working history, these were not consistently explored in order to protect people living in the home.

Inadequate

Is the service safe?

We saw that legally required checks on potential employee's backgrounds had been carried out. These background checks were carried out by the Disclosure and Barring Service (DBS). These checks help the service provider to make an informed decision about the person's suitability to work with vulnerable people. However, we noted that the organisations own policy on recruitment suggested that newly employed staff could start work before a full DBS check had been completed and returned as satisfactory. Such action could place people using the service and others at risk of unsuitable people being employed to work in the service.

The service had a recruitment scoring system that is used to make sure that staff are recruited fairly and appropriately, however, none of the scores had been completed. We saw that these were not used at all for higher-level recruitment; interview notes were written on the reverse of other documentation and did not contain scoring. The provider stated that these were her notes and she accepted it was possibly not the best method to ensure that the most appropriate and skilled staff were recruited.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not following its own arrangements to recruit staff safely.

We looked at how many skilled staff were employed in the service to meet people's needs. People who lived in the service told us that there were, "lots" of staff available. Relatives stated that there were always many members of staff around. Comments regarding the staffing levels and availability were positive and people were complementary as to the kindness and attendance of staff.

We spoke to the manager who informed us that at the time of our inspection, as the service was new, there was no means to determine the number of staff available based on people's assessed needs. The manager also explained that at present staffing levels were sufficient on a day-to-day basis. Staff spoken with also confirmed that, in general, they thought that there was sufficient staff available to meet the needs of people living in the service. They did however, express concerns as to poor recruitment of nursing staff. This meant that the majority of nursing staff available were not employed by the service but worked through an agency . As such, agency staff were not always familiar with the service or the people who lived there. The manager did explain that they do endeavour to use the same agency staff in order that they can be familiar with the service and people living in the service.

Inadequate

Is the service effective?

Our findings

People we spoke with told us that they enjoyed the food that was available to them. Relatives told us that they thought there was plenty to eat and that drinks were available.

We looked at how the service supported people to eat and drink and the arrangements in place to meet people's nutritional needs.

We observed people during the lunchtime period over two days and saw that support to eat meals was appropriate. Meal times were relaxed and unhurried. All of the mealtimes were well organised with people being supported to eat appropriately. Staff reported that kitchen staff assisted them to give out meals in order that they remained hot. However we did see one example were staff did not appropriately support a person to have a drink. We observed one person to be given a drink whilst the member of staff stood over them.

Kitchen staff we spoke with explained that all the meals were prepacked off site. The staff explained that, as a result, they were unable to fortify food appropriately for people losing weight. This limited the kitchens staff's ability to provide appropriate diets, and meet peoples needs.

The kitchen staff were able to provide meals that were of a thickened consistency for people with swallowing difficulties, but were unaware of what consistency they were thickened to or what consistency individual people needed their food thickened to. We observed staff using thickener in people's drinks. When we asked what consistency the drinks should be we received a variety of different answers. There was information available in the service that described the consistency needed but staff were not following this information. There was no monitoring arrangements within the service that made sure staff recorded the usage of the thickener at all or that it was used correctly. This placed people at risk of not receiving their food and drink in a safe manner.

Menus had been set by the company that provided the pre-packed food. There was no information available in the service to highlight what special diets the food was suitable for and as a result, this information could not be passed on to people living in the service. Additionally, the menus did not highlight if the food was nutritionally of value. As the meals were individually pre-packed there was no evidence to demonstrate that people could have larger portions if they wanted. This meant that some people may not be receiving the right level of nutrition they require or could still be hungry following their meal.

Records showed that at least five people were on supplementary drinks. All had fortified diet instructions from nutritionals that were not followed. Although staff were recording the food offered, they did not always record the amount of food the individual person had eaten. We spoke with nursing staff who did not check the food records showing what was eaten by people in order to monitor their nutritional intake. The supplementary drinks were not always recorded on diet or on medication records. As a result, the service was unaware if people were getting their supplementary drinks or not.

Prior to the inspection there were concerns raised regarding people losing weight. At the time of our inspection a dietetic assistant visiting the service gave positive feedback about the response the dieticians had received from Darnton House. We were told by the dietician that the staff were responsive to suggestions and would follow up on ideas and instruction.

We saw in the records that where weights of individuals were to be monitored, this was not always done. Assessments to determine the risk of poor nutrition were not correctly calculated to show the relevant risk or what action needed to be taken. Care staff we spoke with told us they did not read care records and therefore, were not always aware of who was at risk of poor nutritional intake.

One person was listed on an information board as a diabetic who needed insulin. In their care records, it stated they did not need insulin. We spoke with the staff about this discrepancy and they explained that the person's needs varied. There was no information at all within the care records that would support staff to make sure that they suitably assisted the person with the management of their diabetes or that the person received a suitable diabetic diet.

Soft diets were available however; the menu choices did not offer someone on a soft diet two choices and as a result the staff made those decisions.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure that people's individual nutritional needs were met.

Inadequate

Is the service effective?

We looked at how staff were inducted to the service. The induction was a large list of items, mainly to do with orientation to the service and detailed that this was all completed in a single day. In all cases, it was signed by the person undertaking the induction and the person being inducted. However, there was no explanation available as to how such a list of items could be covered thoroughly in one day and at a level that would have introduced staff appropriately to the needs of people living in the service and how to manage those appropriately. Additionally, the induction was general and did not take into account the different practices amongst the three floors of the service or the differing needs of the people living in the service. Overall, the induction would have orientated the staff to the building and practices but would have been unable to give staff the specific understanding they would need in their job role to meet people's individual needs in the one day allotted timescale.

There was no evidence of nursing qualifications on nursing staff files. All nurses are required to register with the Nursing and Midwifery Council (NMC) on commencement of their nursing training. At registration, they receive a unique number known as PIN. A PIN is renewed each year and show that a person is on the register and has paid the fees for the year; they are not evidence of what qualifications the nurse holds. We saw that PIN numbers had been checked initially but there was no system in place to check that these were renewed each year. There were limited training certificates for the majority of staff. The several files we looked at did not contain any evidence of any training.

We looked at how the service managed the training and competency of staff. Staff who gave out medicines had not all received training and their competency assessed. We saw one competency assessment for one person, but this did not show any observations of the persons practice, or confirm their knowledge. There had been four staff, up to the date of the inspection suspended for not giving out medicines safely.

A review of staff training showed that this was out of date or not in place. This was particularly noticeable with regards to the mental capacity act and safeguarding training. We saw examples throughout the inspection where staff demonstrated a lack of understanding of safeguarding and supporting people with fluctuating mental capacity.

Despite a request, we were unable to locate a training plan that made sure staff were up-to-date with training and what training the service considers was essential for the role staff were to undertake.

There was was a supervision policy. However, the majority o staff had not received any formal supervision since they commenced employment. Staff told us that they had not had the opportunity to discuss their views of the service with the previous manager, current manager or provider.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have sufficient arrangements in place to ensure that that staff were suitably qualified, competent and skilled in order to meet the needs of people living in the service.

Observations during the inspection showed that, whilst staff talked to people in a caring manner and demonstrated a caring attitude, they were not all able to communicate effectively with people who required additional communication input, such as people with dementia care needs. This meant that some people living with dementia could become isolated through lack of interaction and communication with staff and others.

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

People who lack capacity can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Mental capacity assessments to determine if somebody had fluctuating capacity, and to determine the best time and way to support them, were not in place. Information

about people's mental capacity and how to support them to make decisions or give consent was not included in people's care records. The home provided support to people living with dementia. There was a lack of appropriate arrangements for supporting people with fluctuating capacity as the service did not have arrangements in place to make sure that people living with dementia had their mental capacity needs met.

We discussed with staff their understanding of how to support people who lacked capacity and their understanding of the law to support this, such as, the Mental Capacity Act 2005 and its associated codes of practice (MCA). Staff members' understanding was inconsistent with some staff being able to explain clearly how to support people, whilst others demonstrated a limited understanding, particularly in relation to people living with dementia.

We spoke with staff and the manager about who had a lasting power of attorney. A lasting power of attorney is a legal arrangement that supports the relatives of people to make decisions on their behalf. The lasting power of attorney information and the decisions allowed were not reflected in people's care records. There were no records available for this and there was no ability within the service to identify if a lasting powers of attorney were in place or what legal authorisation a relative may have to act on behalf of their relative.

We saw on the top floor that Do Not Attempt Resuscitation (DNAR) arrangements in place were not made available to staff. DNAR from the hospital were in place but these were not transferable and as such any arrangements that had been in place in the hospital were no longer relevant as they had not been updated or reviewed as relevant. We were unable to find any records of a best interest meeting and capacity assessment prior to the development of DNAR by the service. As such, this significant decision had been made without making sure that a person's rights were maintained.

One person was receiving medicines that are known as covert. This means the person was not aware that they were taking them. The service had received an email from a doctor given permission to do this. However, there were no records that the person did not have capacity, whether a best interest meeting had been held or clear care planning as to what actions staff needed to take prior to giving the medicines. Additionally, there was no information that where tablets were to be crushed, that this was appropriate to do or what medicines were essential. The policy for medicines available on two floors of the service did detail the necessary arrangements for covert medicines, but a lack of understanding on behalf of the staff regarding the MCA meant that staff were not following the policy.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the home.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The records within the service and discussions with the manager and the provider showed that they were unable to identify what DoLS authorisations had been applied for, where the authorisations were up to, if the order had been granted, and if so, for what timescale. As such, the service was unlawfully depriving people of their liberty and was unable to make sure that any authorisations in place were correctly monitored. We observed, as an example, that one person was supervised constantly by staff due to concerns regarding their ability to manage their behaviour. There was no DoLS authorisation in place to restrict the person's liberty and the service was unable to determine if one had been applied for or granted. As result, the person's rights had not been recognised and the potential abuse of those rights had not been acted on.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure that people's rights were maintained.

We looked at how the service had been adapted to meet the variety of needs of people living in the service. The service is a new service and was built for the purpose of accommodating people requiring health and social care support. All areas are well decorated and to a high standard. This presented as an environment that is spacious and modern.

On the days of our inspection we found that the communal areas in some cases may not be suitable for some people

with poor or limited eyesight. This was because all the main corridors had very low lighting. Each floor has a room that is designated as the cinema room with a large screen television. There were other lounge areas within the service where televisions were available. We saw that these cinema rooms were dark as the lighting was subdued. We saw people sitting in both these areas for long periods of time.

The ground floor is designated as used by people with dementia care needs. We saw that this floor did not support people with dementia care needs to be as independent as possible. Each of the doors were all brown and there was no signage that would assist people with dementia or other communication and visual needs to move around the service independently. Attempts had been made to use "memory boxes" this included photos in a box next to bedroom doors. However, due to the low lighting, we found these difficult to see and in some cases did not use imagery that the person would be able recognise as relevant to them.

The top floor of the service had a keycode to the door for both exit and entry. However part of the admittance criteria for this floor is that people must have capacity. There was no arrangements in place to give people access to the code to allow them to come and go freely. This meant people's liberty was being deprived.

Bedrooms all had the ability to lock independently and a key given to people living in the home who requested them. We discussed this with staff, people living in the service and other stakeholders from the hospital. There had not been any arrangements put into place to allow people to have their own key to their bedrooms. We saw all bedroom doors for people living in the service were unlocked regardless of whether the person was spending the day elsewhere in the service.

There was an outdoor space available however; this contained a large plastic cow that could blow around the garden on a windy day. The garden area was not adapted for the differing needs of people living in the service. This meant that people using the service could have their right to freedom to access the outdoor space restricted.

Inadequate

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was positive. Some people spoke positively about the care provided by staff. Comments included, “flawless”, “So kind and caring, I wish [name of person] could stay here all the time. It’s lovely.”

We saw information on advocacy services was not displayed. The only information we saw on display was a notice to visitors that meals were for people living in the service. None of the people we spoke with were aware of what advocacy services were available. As some people lacked capacity and there were no clear arrangements in place to show who could legally act on their behalf. The arrangements for advocacy were not able to meet people’s individual needs.

We used the Short Observational Framework for Inspection (SOFI) on the first day of the inspection over lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We did see however that some staffs communication methods with people living with dementia or sensory impairment did not meet their needs.

One person who was deaf and not wearing hearing aids, was repeatedly asked the same question by a staff member. It had to be highlighted to this staff member by the inspectors, that the person required communication aids. One person who had been assessed as needing glasses was not wearing their glasses. Another person was wearing glasses that were dirty and had been broken, they were taped at arms and they did not fit properly. A further person had records stating that they needed glasses to see but were not wearing their glasses. We spoke to staff regarding the support to people with sensory impairment, but they were not aware of what aids people needed.

We saw no evidence that people were able to participate in activities during our inspection visit. Three people we spoke with told us there was very little to occupy them and they had very little to do during the day. People using the service lacked opportunities to participate in activities that would encourage their independence and reduce the possibility of social isolation. Care plans did not identify activities that people may have been involved with when living at home or activities that people may have an interest in participating in whilst living in Darnton House.

There was no information within the service, that was in a format suitable for people living with dementia regarding choices, as observed over meal times. No information in the service that was available in different formats such as large print to meet individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure that care and support was provided in a way that was designed to meet people’s preferences.

On the Transitional Care Unit (TCU) we saw that confidential records were left on view in people’s bedrooms as medical staff had wished to review these and did not want to not disturb nursing staff in their duties. The records had been removed from a locked space therefore breaching people’s confidentiality.

We looked at arrangements in place for supporting people at the end of life. We saw that the needs of people receiving end of life care were not recorded and kept under review. In some examples, there was no care plan in place for the person’s end of life needs and wishes, or arrangements to ensure that the person’s preferences were kept under review and acted on.

Although the service did undertake end of life care., records showed that most of the staff had not received training in this area. Staff we spoke with were confident that they could support an individual appropriately with any care they needed at the end of their life. We reviewed records available within the service and this showed that there was no discussion with people around their wishes at the end of their lives or what advanced decisions they would like to make.

We looked at how the service supported the dignity of people living in the service. All the people we spoke with had appropriate clothing on and looked well presented. Observations showed us that people were addressed appropriately and treated with dignity. We saw and heard staff and people using the service enjoying chatting and laughing about different things. This indicated that people using the service felt comfortable with the staff on duty.

Care, when delivered, was undertaken behind closed doors in order to preserve people’s dignity and staff knocked on doors before entering.

Inadequate

Is the service responsive?

Our findings

People living in the home told us that they had limited or no input into deciding on the activities or meals available. One person told us, "Nobody has ever asked me what time I would like to go to bed or when I would like my meals. However, if I don't want to eat at a certain time they will keep it for me to have later." People spoken with reported that their visitors were welcomed into the service. On e relative told us that they always felt welcomed and were offered a cup of tea and a meal if they visited during mealtimes.

The menu available in the home did show a choice of food. The manager and kitchen staff confirmed that as yet people had not been asked about what they would like to see on the menu. Kitchen staff told us that meal times, and when lighter meals were to be given, were changed without consultation with the people living in the service.

There was no information available regarding activities and no activities were observed during the two days of our inspection. Feedback from people confirmed that there was not enough for them to do and we observed there was limited stimulation for people.

We spoke with people living in the home about how the home supported their cultural needs. Care records viewed did not highlight people's religion or if they required any support to have their cultural needs met. We spoke to people about their preferences to have their personal care needs met by staff of the same sex. None of the people we spoke with could recall being asked what their preferences were.

There were two types of records in use across the home; records on the first two floors were complex and large and contained information that quickly went out of date and in some cases, had not been updated correctly. The records on the top floor gave very limited information and did not inform staff how to support people. None of the care records and assessments we viewed had been undertaken with the involvement of the person or their representative. None were signed by the person or their representatives. Staff confirmed that although they did involve people in the assessment process they did not get them to check the information once completed and confirm its accuracy.

We did see a history of a person that included family photographs and stories about the person. However, this had been undertaken by the Speech and Language Team (SALT) and was not part of the service's own systems. The care records we viewed prepared by the service contained minimal information about who the person was, what their preferences were, their cultural needs or how they wished to live their lives. The records and plans centred on the persons physical needs but little or no information was included on their social needs. We saw that there was very little or no information available in people care records that would assist staff to help people make choices. We asked for information that showed us how people who were less able to vocalise a choice, such as food or activities, were supported to take into account their personal preferences. The manager and staff told us that no information was available. Staff told us that they often made choices for people living in the service. We did see that one person preferred a no meat diet and this was supplied to them.

We looked at how the service responded to people's health care needs and made sure that they received care that met their needs. We reviewed six care plans in total. None of which were person centred, with the same generic plans available for different people such as how to support a hygiene need. Care plans were "task and medical condition" orientated and not person orientated. People's individual needs were not recorded in plans, for example one person had behavioural concerns and these were not recorded in their care plan. There was no information available to staff that told them how to respond when this person became upset or distressed.

Nursing staff on the top floor informed us that they had been directed to make sure that they gave medicines out between 8 am and 10 am regardless of the individual routine of the individual.

We spoke with health care professionals who visited the service. They told us that they thought staff did their best but needed further development to respond to people's individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements in place to make sure that people received care and treatment that met their needs, reflected their preferences and was appropriate.

Inadequate

Is the service responsive?

The complaints policy and the means to raise concerns was not on open display in the service. We were informed that it was in the information given to people when they were admitted to the service. We checked peoples bedrooms and spoke to people living in the service, but we were unable to locate the information.

The manager provided a copy of the service's complaints policy. The policy did not allow a complaint to pass directly to the provider and it also implied that complaints can be made directly to the Care Quality Commission (CQC) and social services directly for investigation. The policy did not make any provision for people, their relatives or staff to raise concerns anonymously should this be appropriate.

At this inspection, we asked to see how complaints were being progressed and what any investigations had revealed. There were no investigation records available and the registered manager explained that they unaware of how many complaints they had received. They initially told us that there was one complaint and produced a record that did not show a full investigation or response to the complainant. On reviewing records and after discussions with staff, there were a number of complaints that had been made. We were eventually provided with three different figures as to how many complaints had been made. The service was unable to make sure that they were aware of what complaints had been made and to address both the satisfaction of the complainant and to make sure that lessons were learnt.

Prior to the inspection, the CQC had been approached by family members and whistleblowers raising concerns that had not been addressed or actioned by the service.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have an effective system to ensure that they recognised, investigated and responded to complaints in a timely manner.

Inadequate

Is the service well-led?

Our findings

The culture of the service was not based on the needs of the people who lived in the home but was task orientated. This could be seen by the routines in place in the service that were not flexible to meet people's needs, the lack of choices available to people, care that did not meet people's needs and care that was not appropriately planned.

A manager was in place on the date of the inspection but they were not registered with the Care Quality Commission. 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.

The provider did not have a formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. There was some evidence of recent quality monitoring of medication and an audit had been completed by the service. This audit had identified some of the gaps in practice identified at this inspection, however, this had not been shared with the staff to improve their practice or an action plan in place to bring about improvements.

We found that the service was not aware of how many incidents of suspected abuse were being investigated, how many complaints they had received or how may applications for Deprivation of Liberty Safeguards (DoLS) had been authorised. The systems in place were not sufficient to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas; these included medication, meeting people's choices, stimulating activities for people who lived in the service, recognising risk, care and welfare, dealing with complaints, identifying and managing safeguarding and staff training.

A care plan audit had been undertaken; however, care records did not record people's needs and plans of how to meet those needs accurately. Staff said they did not read care records and records did not reflect needs. We found several instances of care not meeting people's needs. These issues could have been identified through a formal system to assess and monitor the quality of care if one had been in place. At the inspection, we identified four people whose care needs had not been fully met and required investigation as part of a potential neglect concern. The services systems had failed to recognise concerns or action them appropriately.

Where issues or improvements had been identified, we saw appropriate action had not always been taken to address them. For example, unexplained bruising on a person had not been investigated and complaints had not been addressed.

Policies and procedures were not all specific to the service. Policies were inconsistent with different practices in operation within the service, such as different processes on the top floor for medicines as examples without policies in place for these practices. Several of the policies we viewed were out of date, having been purchased from a private company in advance of the service opening. These policies were without consistency for subject, content, review and implementation. The policies in place did not reflect the practice in the service and as such, did not guide staff to make sure they had a consistent approach in their job role.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. For example, we found accidents or injuries that were recorded in people's care records and accident records. These had not been analysed or actions taken to determine the cause and prevent them from reoccurring. We saw that peoples care records such as diets, medications, behavioural needs were not reviewed and changes to care highlighted in order to improve people's care experiences.

People who lived in the home and the staff had not had the opportunity to give their views and opinions of the care provided or any input for improvement.

We asked to see a copy of the audits that the provider undertook in the service. We were informed by the provider that they did not undertake audits, however, they had recognised the need to do so and had plans in place to address this in the future.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements to assess and improve the quality of the service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The service did not have an effective system in place that recognised potential abuse or took appropriate action taken when concerns were identified.** **Regulation 13 (1) (2) & (3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was failing to ensure that service users received care, and treatment that was provided in a safe way.** **Regulation 12 (1) (2) (a) & (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider was not following its own arrangements to recruit staff safely.** **Regulation 19 (2) & (3) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

	The provider did not ensure that people's individual nutritional needs were met. **Regulation 14 (4) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have sufficient arrangements in place to ensure that that staff were suitably qualified, competent and skilled in order to meet the needs of people living in the service.** **Regulation 18 (1) (2) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the home.** **Regulation 11 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure that people's rights were maintained.** **Regulation 13 (1) (5)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not ensure that care and support was provided in a way that was designed to meet people's preferences.** **Regulation 9 (1) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have suitable arrangements in place to make sure that people received care and treatment that met their needs, reflected their preferences and was appropriate.** **Regulation 9 (1) (a) (b) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not have an effective system to ensure that they recognised, investigated and responded to complaints in a timely manner.** **Regulation 16 (1) (2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have suitable arrangements to assess and improve the quality of the service provided.

Regulation 17 (1) (2) (a)