London Borough of Haringey

Osborne Grove Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Prior to this inspection, we carried out an unannounced comprehensive inspection of this service on 6 and 7 December 2016. At that time, we found breaches of seven legal requirements. We rated the service as 'Requires Improvement' and we served four enforcement warning notices on the provider, London Borough of Haringey. These were in respect of safe care and treatment, meeting nutritional and hydration needs, person centred care and good governance. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements.

We carried out this focused inspection on 22 and 30 March 2017 to check that the provider had followed their action plan and to confirm that they now met the legal requirements relating to the four warning notices.

This report only covers our findings in relation to the four warning notices. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Osborne Grove Nursing Home on our website at www.cqc.org.uk.

Osborne Grove Nursing Home is registered to provide accommodation and personal and nursing care for up to 32 people. The home is run by the London Borough of Haringey. There were 19 people using the service at the time of this inspection. Commissioners had imposed an embargo on new people moving into the home due to concerns about the quality of care provided until improvements were made. No further admissions were planned at the time of the inspection.

There was a registered manager but they had been on extended leave since 1 December 2016. 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 temporary manager at our last inspection on 6 and 7 December 2016 had left as had their line manager. A new management team had been in place for a few weeks at the time of this inspection. The new manager had been in post since January 2017 and was applying for registration. A deputy manager had been in post since December 2016 and a nurse consultant to oversee the management of the home since February 2017.

At this inspection, we found that the provider remained in breach of legal requirements relating to safe care and treatment, meeting nutritional and hydration needs, person centred care and good governance, despite some evidence of addressing matters relating to our warning notices. None of the warning notices were fully complied with.

We found care plans had improved but records of care provided showed that care was not always provided

in accordance with the person's care plan. One example of this was "turning charts". Where a person's care plan stated that they were at high risk of pressure ulcers and should be supported to change position or "turn" every two or four hours, charts showed this was not always carried out. There was insufficient evidence that some people at high risk of developing pressure ulcers were supported to change position regularly, especially at night, in accordance with their plan of care.

Two people had care plans stating that they needed to take prescribed food supplements and be offered snacks between meals as there were concerns about weight loss. The food/fluid records showed that they were not always offered these.

Moving and handling equipment to help staff move people who were unable to get up by themselves had improved since the last inspection as staff had attended further training in using the hoists safely and each person had their own named sling for use with the hoist which improved safety and reduced infection control risk. However pressure relieving mattresses to reduce the risks of people sustaining pressure ulcers were not in good condition. There were no records of staff checking them regularly to make sure they were clean and working properly. The manufacturer had recently audited the equipment and found some were not fit for purpose. The provider had ordered new mattresses which were being delivered the day after our inspection.

The home was generally clean and had suitable hand washing facilities but we found some bedroom floors and furniture to be sticky and armchairs in lounges and beds not cleaned regularly which was an infection control risk.

There was not enough stimulation for people and limited opportunity to go outside the home.

Records of the care provided to people were not consistently accurate and complete. This meant that there was insufficient evidence of safe care and treatment.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures 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. If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The breaches of regulations identified in this report indicate ineffective governance of the service. There were insufficient improvements despite us serving four warning Notices on the provider soon after our last inspection. As a result of the concerns we identified, that the provider was not meeting the needs of people

using the service who may therefore have been at risk of harm, we sent the provider a letter of intent after the inspection, outlining our most serious concerns. The letter informed the provider of enforcement action we were considering, and requested an urgent action plan setting out how the provider intended to address these concerns. An action plan was promptly sent that planned to address the most serious concerns. We therefore reviewed our enforcement options, and served four enforcement Warning Notices on London Borough of Haringey to help ensure that prompt action is taken to address the concerns we identified during this inspection.

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. A warning notice about safe care and treatment had not been fully complied with. People had individual risk assessments to identify risks and manage them but some risks had not been adequately managed leading to unsafe care for one person and risk of unsafe care for others.

Staff knew how to identify abuse and the correct procedures to follow if they suspected that abuse had occurred.

At the time of this inspection, a number of beds and mattresses had been assessed as not fit for use and replacements had been ordered. There was no evidence of regular cleaning and checking of beds and mattresses by the provider other than the six monthly checks by the supplier.

There was no written assessment of staffing needs for the home so we could not confirm there were enough staff to meet people's needs. We noted an increase in nurses during the day.

Hoisting equipment had been serviced and each person who needed to use a hoist had their own sling which reduced any risks to their safety and infection control.

Is the service effective?

Requires Improvement

The service was not consistently effective. A warning notice relating to nutritional and hydration needs had not been fully complied with. Some people's nutritional and hydration needs were not being met and two people were not receiving prescribed dietary supplements needed for weight gain.

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People received support to meet their health care needs from external professionals such as the GP, dietician and tissue viability nurse.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. A warning notice about person centred care had not been fully complied with. Care plans were not always person-centred. There had been an

improvement in care plans but these were not always implemented to meet the person's needs. There was a lack of action to promote continence. People were not given a choice about how they received personal care. People said they did not have enough to do. There was a limited programme of activities but this was not enough to meet everybody's needs.

Is the service well-led?

Inadequate

The service was not well-led. A warning notice regarding good governance had not been fully complied with. There were ineffective governance systems in place as there were insufficient improvements to the health, safety and welfare of people using the service despite us serving four Warning Notices on the provider following our last inspection.

Concerns and risks identified during our inspection had not been identified by the management team and the provider had not addressed these.

A lack of consistent leadership and a lack of audits of the quality of the service left people at risk of inappropriate or unsafe care.

Osborne Grove 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.

We carried out this unannounced focused inspection of Osborne Grove Nursing Home on 22 and 30 March 2017. This inspection was to check whether improvements had been made to meet the legal requirements of four Warning Notices that we served on the provider following our last inspection of 6 and 7 December 2016. The team inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well-led? This is because the service was not meeting some legal requirements in those areas at our last inspection.

Before this inspection, we reviewed all the information we held on our database about the service and provider. This included notifications, concerns and safeguarding alerts, and information provided from the local authority and Clinical Commissioning Group (CCG).

The inspection was carried out by two inspectors, a pharmacist specialist, a Specialist Professional Advisor who was a nurse and an Expert by Experience who is a person who has personal experience of using or caring for someone who uses this type of care service.
There were 19 people living in the home at the time of this inspection in three units; Snowdrop, Lavender and Carnation. A fourth unit was empty and being used for storage.

During the inspection, we met all 19 people and spoke with nine individually. We also spoke with three relatives of people living in the home, three care assistants, two nurses, two cooks, the activity coordinator, one domestic assistant, the deputy manager, home manager, nurse consultant overseeing the home on

behalf of Haringey Council and the Head of Operations. We also received feedback from five health and social care professionals and the local authority commissioning team during the course of the inspection.

We looked around the building including some people's bedrooms, communal areas and equipment. We observed care, interactions between staff and people living in the home and mealtimes in each of the three units and attended a staff handover meeting.

We looked at care records for five people living in the home, 19 medicine administration records and we carried out pathway tracking for five people. This involved reading their risk assessments and care plans and looking at their daily records and all charts (food and fluid, continence, repositioning, wound care, hourly checks) and visiting them to see if the planned care was being provided. We also looked at maintenance, cleanliness and health and safety records, medicines storage, management records and staff meeting minutes.

Inadequate

Is the service safe?

Our findings

A warning notice issued after the previous inspection in December 2016 due to a failure to comply with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment - had not been fully complied with.

Since the last inspection in December 2016, allegations of neglect leading to two people developing a pressure ulcer were substantiated by the local authority safeguarding team.

People's care plans had been updated since our last inspection. Clinical Commissioning Group quality assurance nurses had supported nurses at the home to improve the care plans. There were risk assessments in place to assess risks to people's health and safety for risks such as pressure ulcers, taking medicines, moving and handling and malnutrition. There were care plans advising staff on how to care for the person to reduce the risks. However the care plans were not always fully implemented so people were at risk of unsafe care and treatment.

The majority of people had a care plan stating that they should be supported to change position regularly to reduce the risk of pressure ulcers. However, we checked turning records for one person and found that they had stayed in bed in one position all night and the following day on 27 and 28 February despite records showing they had a pressure ulcer since 4 February 2017. A new care plan dated 7 March 2017 stated that this person should be prompted or assisted to change position every two hours. On some occasions staff had recorded that the person declined assistance but on some occasions there was no record to explain why they had not helped this person to move position every two hours in accordance with their care plan. A safeguarding investigation found an allegation of neglect against the provider to be substantiated due to their failure to support the person to change position in accordance with their care plan and failure to ensure the correct pressure relieving equipment was provided and working effectively.

Another person had a care plan advising staff that they needed to be supported to change position every two hours during the day and four hourly at night. Records showed gaps of up to 8 hours where the person was left in one position therefore increasing their risk of pressure ulcers. Records (turning charts) showed they had been left sitting for 6 hours one day and 8 hours on another day. This person had a pressure ulcer at the time of the previous inspection due to failure to provide correct pressure relieving equipment or to have support to change position in accordance with their care plan and remained at high risk of developing pressure ulcers.

A healthcare professional informed us of three other people who had gaps in their turning charts indicating that the people had not been supported to change position in accordance with their individual care requirements.

We found the risk of developing pressure ulcers was not mitigated as some people's records showed they were not receiving the support their care plan stated to change position regularly.

People at risk of constipation, dehydration and urinary tract infections had charts in place for staff to monitor this so that they could get safe care and treatment. However, these charts were not always completed daily and there was no checking of the charts by the management team. This meant that staff were not able to accurately assess whether people were at risk. One person had gaps on their bowel chart records in March 2017. Another had no entry for seven days in February 2017 and nine days in March 2017. Another person's chart had been completed but indicated that they had not opened their bowels for 14 days previously. We asked the nurse consultant at the home to check the records and they concurred with this finding. This risk to the person's health had not been noted by staff at the home and so the person had not received any treatment. We had to intervene to ask the nurse consultant to take some action for this person who was then taken to hospital for treatment. We fed back our concerns about the unsafe care and treatment of this person to the provider and they informed us that they implemented a protection plan for this person after the inspection to ensure they received appropriate care.

There were hourly checks on people to check their wellbeing but there were gaps in one person's for five nights' charts so it was not clear whether staff had checked on the person regularly.

The above was a failure to mitigate risk to people's health and safety and failure to provide safe care and treatment.

The provider informed us after the inspection that they had taken steps to improve checking of daily records, including charts used to monitor people's health.

We were unable to check if the home had the correct numbers of staff to meet people's needs as they had not completed a dependency analysis of staffing needs. However an extra nurse had been provided for each shift which was positive.

There was a failure to ensure there was suitable safe equipment for providing personal care in use. The adaptive baths in the home had not been in use at the last inspection in December 2016. At this inspection we found that two of the baths had been serviced and two were awaiting parts. Senior staff informed us that since the last inspection nobody had been able to have a bath. The deputy manager informed us that, although two baths were working, staff said they did not know how to use the baths. She told us that training was being arranged to show staff how to use the bath.

People in the home had hospital type beds with adjustable height, and pressure relieving mattresses. These had been serviced in December 2016 after some mattresses were found not to be functioning correctly. At an audit by the manufacturer in March 2017 a number of beds were found to have defective mattresses or the wrong pump with the pressure mattress. This meant that new mattresses had to be purchased. There was no record of nurses, managers or maintenance staff regularly checking whether pressure mattresses were set correctly according to the person's weight or working properly in between the checks carried out by the supplier.

The findings of the safeguarding investigation carried out by the nurse consultant found that the person who recently developed a pressure ulcer had an incorrect pump for their pressure relieving mattress. This meant that the equipment did not work effectively to prevent pressure ulcers.

Although there had been improvements in the management of medicines since our inspection in December 2016, medicines were not always managed properly and safely. There were no topical Medicines Administration Records (MAR) charts to advise staff where on a person's body a topical medicine such as ointment or cream should be applied so there was a risk staff would not know where to apply creams.

Two errors on the March medicines administration records had not been noted and addressed by nurses when checking in the monthly delivery of medicines and medicines administration records. One error was an incorrect allergy status on a chart which led us to believe a person was taking a medicine they were allergic to. The deputy manager confirmed that the person was not allergic to the medicine so there was no risk. Another person had an old dose on their MAR when their dose had been changed but the old dose was recorded on the record. Both these errors were acted on immediately that we raised them and there had been no harm to any service user but these errors were not picked up by the home's internal systems for checking medicines are given in a safe way as there could have been a risk of harm.

There were no written protocols for medicines that were given as and when required. Some medicines were for pain relief or treatment of constipation. There were no written guidelines to inform staff when each person might need these medicines and what signs to look out for to assess when and how much they needed. One person had four types of pain relief medicines prescribed and there was no guidance or pain management care plan to advise staff how to assess when this person was in pain and which of the four medicines to give for which type of pain. This lack of guidance leads to risk of a person receiving too much or too little pain relief. We saw that if a variable dose of medicine was given, staff sometimes recorded the exact dose given but not every time. It was not therefore possible to check exactly how many tablets people had taken.

Sharps were disposed of into a sharps bin. The sharps bin had a large opening (which means that there was a risk staff could sustain a needle stick injury whilst using it), and had been in use for longer than 3 months. The Department of Health – Safe management of healthcare waste guidance states that it is good practice to dispose of sharps waste after 3 months.

We saw eight oxygen cylinders being stored in a clinical room. Two of them were empty and were awaiting disposal. The rest were in date and full. Staff did not know why they were storing so much oxygen when none of the current residents of the home used it.

Snowdrop unit medicines fridge had records of the current fridge temperature, but not the minimum and maximum temperatures as per guidance in 'The Handling of Medicines in Social Care – Royal Pharmaceutical Society - 2007 Refrigerated storage. The thermometer was faulty and could not be reset. In addition, we saw a temperature reading of 1.6°c.This was below the required range of 2 – 8°c temperatures, but there was no record of any action taken by staff. The Lavender unit medicines fridge had records of the minimum, current and maximum fridge temperatures, however a number of out of range temperatures were recorded with no record of any appropriate action taken. There was no immediate risk to people because there were few medicines requiring refrigeration in stock at the time of the inspection but a failure to ensure certain medicines are stored at safe temperatures could leave people at risk of receiving medicines which are not effective.

There was insufficient action taken to assess the risk of, and prevent, detect and control the spread of infections. The provider was not following the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. There was no infection control policy in the home. There were no infection control audits available for inspection and the provider told us they had not carried out any infection control audits.

We found some bed bumpers (wipe clean padded covers which go over bedsides to prevent people from hurting themselves on the metal bedside) and recliner chairs were not clean. Some mattresses and recliner chairs had stains and sticky areas. We saw two bed bumpers and two recliner chairs had tears in the fabric which were an infection control risk. The written cleaning schedule for the home did not include cleaning of

chairs, beds, bed bumpers or mattresses.

We observed that these chairs were used by different people who ate meals in the chairs. The manager informed us there were not enough recliner armchairs for each person, so some people got up in the morning and sat in a chair and another person would sit in the chair in the afternoon. There was no record of these chairs being wiped clean between use. We noted four recliner chairs had sticky areas on 22 March 2017. On 30 March 2017 the same sticky marks were still present. We checked these marks and found they were easily wiped off. This showed that the chairs had not been cleaned properly for at least eight days. One chair had a tear in the fabric and another chair in use in December 2016 which had worn areas and tears in the fabric was still being used on 22 March 2017. We were informed that this was taken out of use after the inspection.

We also found some bedroom floors and bedside cabinets had sticky areas and were not clean. This infection control risk had not been acted on. After the inspection the provider informed us that they had arranged a deep clean of the home.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a number of improvements since the last inspection. All hoists were serviced on 1 December 2016 and since then all staff had refresher training on how to move people using a hoist. In addition the provider had purchased an individual hoist sling for each person. This reduced risks associated with safety and cross contamination. A care assistant was able to describe how to support people when using a hoist.

Call bells and a broken radiator guard seen at our last inspection in December 2016 had been repaired.

All prescribed medicines were available, although one item had run out on the day of inspection. Staff told us that they would organise a new supply. All medicines were stored safely and securely and we saw evidence of action taken by staff to ensure the temperature in the clinical room was always safe.

Each MAR chart had a photo to assist staff in identifying the person which had been completed after the last inspection. We discussed the administration of medicines via a percutaneous endoscopic gastrostomy (PEG) feeding tube with the deputy manager as we found a concern with this at the last inspection. They told us that all nurses had received guidelines on the best practice to do this, and were aware not to mix two medicines together, and administer one medicine at a time, and flush the PEG tube in between medicines.

Staff completed medicines training in March 2017 and the nurse consultant told us that the pharmacy providing the medicines was going to provide further training and conduct a medicines audit.

Requires Improvement

Is the service effective?

Our findings

A warning notice issued after the previous inspection in December 2016 due to failure to comply with Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Meeting nutritional and hydration needs had not been fully complied with.

Five people and one person's relative told us they liked the food at the home. Comments included; "I like the food, banana, bread & butter. It is what I like and ask for", "There is plenty of food", Yes it is quite good. There is enough of it" and, "The food I have seen is perfectly acceptable."

On 22 March 2017, the manager showed us a new improved four-week menu. We found that the new menu was not being followed and the cooks were working on a temporary menu which they planned a few days in advance. This was the same finding as at the previous inspection in December 2016. This was evidence of a lack of oversight of people's diet which leaves people at risk of their nutritional needs and preferences not being met. The manager informed us after the inspection that the new menu started shortly afterwards.

There was a list of people who required a fortified diet to maintain or gain weight. We found by reading their records of food eaten that the records were inaccurate. A list of ingredients used to fortify meals had been ticked when the food was prepared before staff knew if the person had eaten those meals. The manager took action to improve this record keeping between 22 and 30 March 2017.

The food chart template used at the home had a space to record snacks mid-morning, mid-afternoon and bedtime. We looked at the charts for the two people at highest risk of weight loss whose care plans stated they should be offered snacks between meals and dietary supplements. These charts recorded either a drink or nothing in the snack section in all the charts we looked at. One person had a care plan dated 7 March 2017 which stated that they should be encouraged to have snacks and drinks between meals and the other had recommendations from a dietitian to have snacks between meals. From 13 March to 18 March 2017 the food recording chart for one person indicated that they had eaten little or nothing. There was no record of any action taken in response to their poor nutritional intake during that time. At the previous inspection in December 2016 we found both these people were losing weight and were not eating enough to maintain their weight. A nurse from the local Clinical Commissioning Group had recommended that one person be offered drinks on an hourly basis but this advice had not been followed. Both people were not being given their dietary supplements twice a day as prescribed. Between 11 and 21 March 2017 records indicated that one of them was given their supplement 5 times instead of the prescribed 20 times. The other person was not being given their prescribed dietary supplements despite not eating and drinking enough. The management team were not overseeing their care and had not identified that they were not being given their supplements. We spoke with the deputy manager at the home during the inspection, who told us that this person's supply of supplements had run out. Weight records showed that both people were weighed once a month and both continued to lose weight despite this concern being raised at the previous inspection and in a warning notice served following that inspection. There was a lack of evidence that staff had taken action to support them to maintain or increase their weight.

There had been an improvement since the last inspection in that a cooked breakfast was now offered once a week and the evening meal had improved as it was previously soup and sandwiches every day and now there was more variety. The new menu includes a variety of meals, snacks and smoothies which had not been implemented in time to comply with the warning notice.

The evidence above demonstrates a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

A warning notice issued after the previous inspection in December 2016 due to failure to comply with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014– person centred care - had not been fully complied with.

There had been some improvement in the number of people getting up every day but there remained a number of people who did not get up every day. Some people were not able to get up until the afternoon due to the number of reclining armchairs available for people to sit in. This was not person centred care. The provider was in the process of purchasing new chairs and assessing people's seating needs with the help of a physiotherapist. One person said, "I don't get up enough it depends if they [Staff] are busy or not, whether I get up." Another said, "It is easier for me to stay in bed. It is my choice as it is such a job to get me up."

One relative said, "They [Staff] get her up first thing in the morning. She is washed and dressed each morning" but another relative said, "Getting up is an issue."

The home had a promoting continence policy but this was not followed. We found that only three of the 19 service users living in the home on 22 March 2017 were using the toilet. These three people were able to walk to the toilet. There had been no improvement since the previous inspection in supporting people to use a toilet or commode if they wished to. The majority of people used incontinence pads but it was not evident whether this was necessary or not as continence was not promoted. The nurse consultant told us they were liaising with a continence advisor but there had been no improvement in time to comply with the warning notice.

People did not have a choice of having a bath or shower. Unless they could walk into the shower they were washed in their bed. Care plans recorded whether service users preferred a bath, shower or wash in bed but in practice there was no choice available for 16 of the 19 service users. Three people who were able to walk to the bathroom had regular showers. The other 16 had not had a shower or bath since our last inspection in December 2016. The deputy clinical manager and the nurse consultant informed us that this was because staff did not know how to use the baths and that 16 people were unable to sit in a chair in the shower due to physical disability or health reasons. People's individual choices could not therefore be met.

There was a lack of daily stimulation for people. One person told us, "If I use the call bell they sort of respond. At weekends there is no one up here. But you still get the food but no attention." Another person said, "They do check in on me, but this is dependant to who is on duty." This indicated that some people who stayed in their rooms felt isolated. There was a lack of person centred activity.

Another person was satisfied and said, "Yes. And they always come when I use it" when we asked if they used their call bell to ask staff for help. A relative said, "In the last 2 months we have begun to notice our mother is more in her room. Prior to that she used to participate in activities."

There had been some improvement in group activities since the last inspection and an entertainer visited on the first day of the inspection for a musical activity. On the first day of this inspection we didn't see any individual activity/interaction other than task based, i.e. helping someone to eat, drink or get dressed. People had individual activity plans but these were not always followed in practice. For the majority of people there was no opportunity to leave the home to go out but there had been one small group outing recently to a day centre for tea.

The above was evidence of a breach of Regulation 9 of the Health and social Care Act (2008) Regulations 2014.

On the second day of the inspection we saw the activity coordinator assisted people to use the garden, one for a walk around and then two people sat in the garden for drinks and to eat fruits from their cultural background which was a really positive experience that they clearly enjoyed as they talked about their memories of picking the fruit when they were young.

Inadequate

Is the service well-led?

Our findings

A warning notice issued after the previous inspection in December 2016 due to failure to comply with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – good governance - had not been fully complied with.

The registered manager had been on extended leave since 1 December 2016. The manager at our last inspection, who was temporary, had left. A new manager had been appointed shortly afterwards and was in post for approximately 6 weeks at the time of this inspection. A new deputy manager to oversee clinical care had started in December 2016 and a nurse consultant to oversee the management of the service on behalf of the provider started in February 2017. We met the management team during this inspection. None of them had been working at the home at the time of the last inspection when the warning notices were served.

At our last inspection, our findings included that there were ineffective governance systems in place, as we identified shortfalls that the management team and the provider had not recognised or addressed. Despite a warning notice being served there was still insufficient evidence of any audits or written reports of monitoring visits by the provider to check on the governance of the home.

There was a lack of effective systems to enable the provider to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate any risks to the health, safety and welfare of people living in the home. Daily building checks which started following the last inspection had been delegated to a temporary member of staff and were not taking place every day and did not identify the cleanliness issues we found.

A visit from a local authority professional pointed out bread in the fridge past its use by date in January 2017. Kitchen staff had explained that the bread was stored in the freezer and removed into fridge however there was no system in place to indicate when bread taken out freezer as it was not dated. When we checked this in March 2017 we found the same issue. Staff agreed to immediately label food with date taken out of freezer but there had been a lack of oversight of the kitchen practices. The manager informed us they would be providing more supervision and support to kitchen staff after the inspection.

There had been ineffective oversight of the management of medicines in the home. We raised concerns about the quality of medicines audits at the previous inspection and in a warning notice but although improvements had been made in medicines management, the audits remained the same quality until March 2017 when the provider introduced a new and improved audit system. On 22 March 2017 we found two gaps on medicines administration records that the management team had not identified through their own systems and two errors on charts supplied by the pharmacy that they had not identified. These were quickly remedied when we raised them with the management team.

One person had acquired a pressure ulcer in November 2016 through not being cared for in accordance with their care plan and not having the correct pressure relieving equipment. There was a failure to assess,

monitor and mitigate the risks of a similar incident occurring. A second person was found to have acquired a pressure sore on 4 February 2017. An investigation by the nurse consultant found that this was due to the same reasons that caused the first person to develop a pressure sore' incorrect pressure relieving mattress and lack of support to change position as directed by the care plan. The provider had not evaluated risk and improved practice sufficiently to prevent another avoidable pressure ulcer.

The concerns we found in relation to people being supported to change position in accordance with their care plan to prevent pressure sores had not been identified and addressed by the provider or management team in the home.

Nurses had areas of responsibility but the management team did not have any written information available to explain what the role entailed. There was a nurse with lead responsibility for infection control but there was no infection control policy in place or audits.

We raised a concern in December 2016 that some staff had no appraisal in 2016 and this was included in a warning notice. Since that date the manager said only one staff member had been appraised. Staff said they still did not receive regular supervision. One staff member said they had two supervision sessions in the last two years and another did not remember when their last supervision session was.

The provider informed us of plans to keep old confidential records in a secure place but had not done so by the compliance date of 17 February 2017 given in a warning notice. On 22 and 30 March 2017 we saw these records kept in an unlocked room along with cleaning products that were not locked away in accordance with guidance for Control of Substances Hazardous to Health. They informed us that this would be rectified the day after the inspection.

There were no written audits of care provided in the home. Care plans had been reviewed and improved since the last inspection but there was no written evidence of any oversight of care delivery records by the manager, deputy manager or nurse consultant who were the management team in the home. Care delivery records are records of care provided to people, such as helping them reposition themselves to prevent pressure ulcers, supporting them with personal care to wash, dress and use the toilet or monitoring of food and fluid intake and output for those who required this level of monitoring for their health. There was no written evidence of any oversight of care records by any representative on behalf of the provider. This meant that they did not know whether care plans were being followed correctly. A lack of effective systems and processes to monitor risks and quality of care left people at risk of receiving inappropriate or unsafe care and treatment.

The record keeping system required staff to complete several charts and records for each person. The Head of Operations told us they were considering moving to an electronic system of recording care provided which would be more effective and less time consuming.

Another example of a lack of oversight was that the management team did not oversee the meals and were not aware that the kitchen staff were not following a new improved menu that the manager had developed.

The deputy manager told us that training was arranged for staff on how to use the baths. We were unable to find out why this matter had not been addressed by the provider before we raised it in December 2016 as it was evidently a longstanding issue that people were not offered opportunity to have a bath.

We found from our inspection of care records that a person was suffering from severe constipation and we had to intervene to ask staff to seek urgent treatment for this person as the lack of oversight of care records

by nurses and managers meant they were not aware of this person's current state of health. This left the person at significant risk of harm.

The breaches of regulations identified in this report indicate ongoing ineffective governance of the service. There were insufficient improvements despite us serving four warning notices on the provider soon after our last inspection. The provider remained in breach of all four regulations relating to those warning notices.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff reported that the new manager and deputy manager were approachable and supportive.

The provider had improved submissions of notifications to CQC as required. They had also checked that nurses' registration was up to date to ensure that they remained registered and able to work as nurses in the home. The provider had registered with the Medicines Handling Regulatory Authority to receive alerts about medicines and medical equipment.

The management team had an action plan for making improvements to the quality of the service.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Warning notice for Regulation 9 was not complied with.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Warning notice for Regulation 12 was not complied with.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	Warning notice for Regulation 14 was not complied with.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Warning notice for Regulation 17 was not complied with.

The enforcement action we took:

warning notice