Chivrose Healthcare Limited

Brackley Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection which was conducted on the 30 and 31 March 2016.

Brackley Lodge Nursing Home is registered to provide nursing and personal care for up to 30 people living with a physical disability, dementia and those who require care for adults over 65 years. At the time of this inspection there were 20 people living in the home.

In April 2015 we rated the home as providing an overall 'Inadequate' level of care and support to people and we placed it into special measures. This was due to serious concerns about the safety and well-being of the people who lived there. The provider agreed not to admit any new people until they had improved the care provided and also gave an undertaking to ensure that there was a registered general nurse on all of the shifts, to ensure effective clinical leadership. The service was taken out of special measures following an inspection in September 2015 which found significant improvements had been made.

However since January 2016 there had been an escalation in concerns about the safety and adequacy of the care and support provided to people living in the home. The Local Authority and health commissioners' monitoring officers expressed particular concerns about the overall clinical oversight of the home, staff knowledge and training and a number of safeguarding issues had been raised as to potential neglect of people. In light of these concerns we brought forward a planned inspection.

The service is required to have a registered manager; there was no registered manager at the time of the inspection which has been the situation since April 2015 when the registered manager left. Attempts had been made to secure another registered manager but they had all failed.
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 had employed an acting manager who was in the process of applying to be the registered manager. This person had since left and the provider had recruited another acting manager who was in the process of submitting an application to become the registered manager.

In addition to the collapse of sufficient management arrangements, there was no permanent clinical lead. The provider was relying on agency staff to take the clinical lead without the understanding and oversight of the people living in the home. Staff without managerial experience or the qualifications were left in charge. There had been a high turnover of staff which meant that people were not always being cared for by staff that knew them and understood their needs.

People were not being cared for in a safe and timely way. There was insufficient staff to meet the individual needs of people and there was no clinical oversight. The provider was failing to ensure that an RGN was on duty each shift having previously given an undertaking that this would happen to ensure that people's physical health needs were being appropriately monitored.

Only basic care was being provided and people's choices were being limited due to the level of staff deployed. People's nutrition was not being consistently and accurately monitored and people were losing weight. Mental capacity assessments were not always being undertaken for people who were unable to make decisions for them self.

The systems that were in place to monitor the service and support its development were no longer being followed. Care plans and risk assessments were not being kept up to date which was putting people at unnecessary risk. Different staff were expected to monitor the administration of medicines without the knowledge and oversight of the system.

People's choice and freedom to move around the home was impacted due to the poor staffing levels and staff were not receiving the guidance and support they needed to do their jobs well.

There had been a high turnover of staff and staff had not been given the training to equip them to meet some of the specific needs of people that lived at the home.

The leadership, quality monitoring and governance arrangements had collapsed and needed to be re-established. Records were not accurately being kept; audits had not been completed for some time so there was no steer to drive improvements. There was an absence of day to day clinical and managerial leadership.

We identified a number of areas where the provider was in breach of Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end to this report the action we have asked them to take.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC as the provider has been unable to sustain the improvements it had made following being taken out of 'Special measure' in September 2015.

The purpose of special measures is to:

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

This is the second occasion that this service has been placed in special measures and we will be considering the action that we should take to secure the safety and well being of people living in the home. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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.

There was insufficient staff deployed to safely meet people's assessed needs and recruitment processes needed to be strengthened.

Risk assessments had not been consistently updated to reflect the changing needs of people. Where there had been new admissions the risk assessments were basic and lacked the instruction that staff needed to safely care for people.

There was no oversight of the medicines system so any potential discrepancies would not be picked up and records were not being accurately kept.

People felt safe with the staff but people's freedom and liberty were potentially being restricted.

Health and safety audits were not being undertaken.

Is the service effective?

Inadequate

The service was not effective.

People's nutrition and fluid intake were not being accurately and consistently maintained; people were losing weight.

Advice and support from health care professionals was not always being sought in a timely manner and where advice had been sought the required action had not taken place.

Staff were not receiving regular supervision and support; training was not being kept up to date and staff had not been equipped to support some of the more complex needs of people.

Mental capacity assessments were not always being undertaken and people's preferences and choices were not always being respected.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always respected.

Staff were focussed on the task and had little time to spend with people and people had to wait for their care needs to be met.

People were being cared for by staff that were kind and considerate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Pre admission assessments and reviews were being carried out by staff who did not have the skills and competencies required.

The staff team did not have an in-depth understanding of people's needs and were reliant on care plans and risk assessments which were not up to date.

People were not being cared for in line with their assessed needs, choices or preferences.

People and their families were able to raise complaints and any complaints raised had been responded to within set timescales and action taken as appropriate.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post and the acting manager had only recently taken up their post and was not yet familiar with the home, the staff or the people receiving care.

The quality assurance and governance systems had collapsed, audits had not been undertaken for some time and action had not been taken to ensure that the standards of care were in line with expectations.

Staffing levels and competencies were insufficient to safely care for people. The provider had failed to ensure that there was an RGN on each shift despite previous agreement to do so.

Staff were left without leadership and guidance.

Brackley Lodge 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.

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This inspection took place on 30 and 31 March 2016 and was unannounced. The inspection team comprised of four inspectors.

In planning for our inspection we reviewed the information that we held about the service. This included previous inspection reports, information received and assessed whether statutory notifications had been received. A notification is information about important events which the provider is required to send us by law.

We contacted the Nene Clinical Commissioning Group (NCCG). Clinical Commissioning Groups are groups of GPs who are responsible for designing local health services in England. They do this by commissioning or buying health and care services for Northamptonshire. We contacted Northamptonshire County Council Commissioners who monitor services contracted by the county council and the Safeguarding Team.

Many of the people living at Brackley Lodge were unable to recall their experiences or express their views; however we observed the care they received and the interactions they had with staff. During our inspection we talked with eight people who were able to communicate with us, three relatives and a visiting health professional. We interviewed four permanent care staff and one agency care staff, two agency nurses and three support staff.

We looked at ten peoples' records to check whether their needs were being met. We also looked at all medicine administration records and six staff recruitment records. We made observations about the service

and the way that care was provided. We also used the Short Observational Framework Inspection (SOFI); SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our inspection in April 2015 we found that the provider was in breach of Regulation 18 (1): Staffing. This was because the arrangements for ensuring safe staffing levels were inadequate. During our inspection in September 2015 we found that each person who lived at the home had had their dependency levels assessed and staffing levels had been calculated accordingly. These staffing levels were reflected within the records that we saw and staff told us that they thought they had enough staff.

However, these arrangements have not been maintained and we have recently received a number of concerns us about the inadequacy of the staffing arrangements in the home and about the impact these were having on the quality and safety of care provided to people living in the home. When we inspected in March 2016 we found that staffing arrangements were not robust enough to safely meet peoples assessed needs. We found that staffing levels had not been calculated based on people's dependency levels or in relation to the complexity of their care needs, but instead were calculated on the number of people living in the home. This meant that there were significantly less staff on duty than at the time of our last inspection in September 2015. We found that the staff were over stretched to meet people's holistic needs in a timely way.

Following our inspection in April 2015 we asked the provider to ensure that a registered general nurse (RGN) was always on duty so that people's clinical needs were effectively managed. We reiterated this again following our inspection in September 2015 as we found that this had not consistently happened. During this inspection we again found an RGN was not consistently deployed on each shift and there was a reliance on agency nurses to provide clinical leadership. Yet we found that there was a different agency nurse on duty on each day of our inspection and there was not a consistent clinical team which understood people's needs living in the home. This meant they were unable to effectively provide the clinical leadership and oversight required to ensure that people consistently received the care and support they required.

There were 20 people living at Brackley Lodge when we inspected in March 2016. The lay out of the home was such that the bedrooms were spread over four floors. There were four people being cared for in their own bedroom and four people who preferred to stay in their rooms. The number of staff on duty meant people were often left waiting for their care needs to be met and instructions in care plans were not being followed.

We saw from records that eight people had been assessed to need two care staff to support them with their personal care and their moving and handling needs. Two people also required 1:1 support and one person was on end of life care. At the time of this inspection there were not enough staff to meet these needs and we observed that people were left waiting for support. The staff on duty were stretched to meet the basic needs of people. People who required 1:1 support were not getting this and staff were unable to fulfil the requirements within people's care plans. For example we read in one person's care plan that they needed to be repositioned every 2 hours. We saw that during the daytimes this was not happening as there were insufficient staff to do this. This was putting the person at risk of developing pressure ulcers. Staff struggled to meet the basic needs of people in a safe and timely way.

People told us that there was not enough staff. One person told us "I have waited two and half hours to see a carer." This person had a room on one of the upper floors. Another person told us "The staff are nice but they are always very busy." A member of staff told us "There is not enough staff but that's normal." We spoke to a health professional who had been visiting the home for a number of years they said "They appear under staffed, the staff do try but the lack of management does appear to have an impact."

This was a breach of Regulation 18 (1) Staffing. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2015 we identified concerns about the management of risks associated with people's care and support needs and considered that the provider was in breach of Regulation 12 (Safe care and treatment). In September 2015 we found that significant progress had been made in the assessment and mitigation of risk in relation to the way that people's care was being provided.

However, during this inspection we found that this progress had not been maintained. Risk assessments had not been consistently updated to reflect the changing needs of people. Where there had been new admissions the risk assessments were basic and had not been built upon; they lacked detailed instruction for staff which meant that people were at risk of being cared for by staff that did not have the knowledge and understanding to meet their needs. Anyone who had difficulty with their mobility had plans in place to ensure they maintained their mobility, however staffing levels impacted on staff's ability to meet those needs in a safe and timely way.

Each person had a personal emergency evacuation plan in place, however, it was unclear as to what plan was in place for someone who had been identified as needing four people to assist them in the event of the need to evacuate at night, there were only three staff on duty at night. We asked the head of care what would happen and they were unable to give us a clear explanation, a contingency plan needed to be developed. It was evident that the risks for this person had not been adequately assessed and there had been a lack of robust planning about how to maintain their safety in the case of an emergency.

This was a breach of Regulation 12 (2) (a) Safe care and treatment. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2015 we identified that the provider was in breach of Regulation 12, (2) (g): Safe care and treatment because medicine systems were unsafe. The inspection in September 2015 found that improvements to the medicine systems had been made; there were effective ordering, stock control and safe storage processes in place.

However, during this inspection we found that these improvements had not been maintained. There was now no oversight of the process and records were not always accurately being maintained; a succession of different nurses were expected to maintain the system with little induction to it. There had been no audits of the system since December 2015 which meant that there was a potential if there had been any discrepancies these would not have been picked up and resolved.

There were inconsistencies in relation to people who needed to have their medicines to be taken covertly. We could see for some people a best interest meeting had taken place and that relevant people had been involved in ensuring this happened safely. However, for someone who had recently been admitted we read a note in their file which said they were to be given their medicines covertly but we could not see any evidence of best interest meetings taking place or any consultation with a GP or pharmacist. We spoke to the RGN on duty, who was a nurse from an agency and she said that she was aware of this note but as there

were no clear protocols in place she would not give the medicine covertly and we saw that the person had taken their medicine. This needed to be reviewed to ensure that the person was consistently getting their medicines as they required and if they did need to be given covertly, the necessary safeguards needed to be put in place. An identified consistent clinical lead needed to address these issues.

This was a breach of Regulation 12 (2) (g) Safe care and treatment. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2015 we found that the provider was in breach of Regulation 19: Fit and proper persons employed. This was because staff recruitment processes were poor. In September 2015 we found that improvements had been made but there remained a need to ensure that two references were consistently obtained for all staff. At this inspection we saw that staff continued to be employed without the provider ensuring that two references were obtained and also identified that there was a need to ensure that any nursing staff deployed through an agency were RGN's.

This was a breach of Regulation 19 (1) (b) and 19 (2) Fit and proper persons employed. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in April 2015 we found that the provider was in breach of Regulation 13: Safeguarding service users from abuse and improper treatment. In September 2015 we saw that improvements had been made and that staff had received training in safeguarding and knew what to do if they had a concern.

At this inspection the majority of staff had received training in safeguarding and the staff we spoke to were able to describe the different types of abuse and what action they would take. One member of staff told us "No worry I know who I need to contact and would not hesitate to do so if I saw anything." People told us that they felt safe in the home and with staff. We observed that they were relaxed and saw that they responded positively towards staff. However, we did observe tables being put in front of people without any particular reason i.e. no drink or item was placed on the table and two people were left strapped in their wheelchairs when not being moved. We could see no assessments in place as to why this was the case and staff did not appear to see that this could potentially restrict a person's liberty and freedom of movement as they were being prevented from standing up or moving around.

We saw that fire systems had been tested and a fire drill had been recently undertaken and equipment was stored safely and regularly maintained.

At the last inspection the manager had in place regular health and safety audits, however these had not been undertaken since the manager left in December.

Inadequate

Is the service effective?

Our findings

At our inspection in April 2015 we found that the provider was in breach of Regulation 14: Meeting nutritional and hydration needs. This was because people's nutritional needs were not adequately assessed and people were not supported to obtain an adequate amount of food or fluids. In September 2015 we found that there had been significant improvements and saw that at that time people were receiving enough food and drink to maintain their health and wellbeing. However prior to this inspection we received information raising concerns that people were losing weight and that there was no one employed with the overall oversight of the people living in the home. There were concerns that peoples' nutritional needs were not being monitored.

When we inspected on 30 and 31 March 2016 we found that although systems remained in place to monitor people's nutrition and fluid intake these were not being accurately and consistently maintained. We observed staff completing several food and fluid records at a time as they sat in the lounge, relying on their memory of what had happened earlier in the day. We saw that fluids were not always being recorded nor totalled and that there was no senior member of staff with the overall oversight to review if people were receiving adequate nutrition. The kitchen staff were being relied upon to note when people had not eaten their meals. However at the time of this inspection there were no permanent kitchen staff on duty, with all regular kitchen staff either on leave or off sick. There was no evidence to show that the staff temporarily working in the kitchen maintained adequate records.

At meal times people who needed help to eat had to wait. At one point there was only one member of care staff trying to support eight people in the dining room and deliver meals to people who had chosen to eat in their own rooms. We observed that people who were being nursed in their rooms and needed support to eat, had to wait until a member of staff was available. Lunch was served around 12.50pm but it was after 1.30pm before some people got their food. There were no drinks available to people whilst they ate. People who preferred to eat in their rooms were left to do so and those who did need assistance had to wait.

There was no co-ordinated nor consistent system to record accurately how much people were eating and drinking. We saw from the records we looked at that people were being weighed each month and that people's weight was fluctuating. We noticed one person had lost 9kg since October 2015; it was recorded that they were on a fortified diet and fortified milkshakes were given. However, there was little evidence to confirm that this was happening on a regular basis.

Staffing levels had an impact on the level of interaction staff could have with people. Mealtimes were functional and lacked any social vibe or person centred approach to them. The lack of consistent management meant there was no oversight as to how people's nutritional needs were being met.

This was a breach of Regulation 14 Meeting nutritional and hydration needs. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2015 we found the provider was non-compliant with Regulation 9 (3) (c): Person-centred care. This

was because we found peoples' clinical well-being was not adequately monitored, reviewed or acted upon.

At our inspection in September 2015 we found that the necessary improvements had been achieved. People had had their base line observations such as their blood pressure checked and fluid intake recorded at regular intervals.

During this inspection, however, gaps and inconsistencies in recording were found. Records were incomplete; there were parts of days and whole days where information had not been recorded, such as whether a person had been repositioned or what their fluid intake had been. This left people at risk of developing complications such as dehydration and infections. During the inspection it had been identified by an external professional that a person may be suffering with dehydration so a GP was called. We also identified that people with specific health and behavioural risks were not being appropriately managed and cared for. Advice and support from health care professionals was not being sought in a timely manner and where advice had been sought the action asked to be taken had not be addressed. For example a community psychiatric nurse (CPN) had advised staff to record people's behaviour to establish if there were any patterns or identified causes, these records had not been maintained. The home had also failed to make a referral to an occupational therapist on the advice of the CPN.

This was a breach of Regulation 9 (3) (c) Person centred care. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although a number of people had expressed their wish to stay in their rooms and this was respected we did observe other people whose choices appeared to be being limited due to the number of staff available. For example, we observed one person who kept getting up from their chair wishing to walk. Staff did not support the person's wishes and kept encouraging them to sit back where they were and stay in the lounge area. Another person kept tipping their wheelchair backwards and appeared to indicate they wanted to go somewhere else; again staff encouraged the person to stay where they were and did not offer them the opportunity to move anywhere else. Other people had tables placed in front of their chairs which made it difficult for them to get out if they wanted to. People were not given sufficient opportunities to make their own choices and have these respected.

This was a breach of Regulation 9 (3) (b) Person centred care. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2015, we identified issues about the level of induction; training, supervision and support offered to staff and a range of actions were taken to secure improvement in this area. When we inspected on 30 and 31 March 2016 we found that there had been a significant turnover in the staff group and the majority of the staff who had received the updated training were no longer in post. Staff told us and records confirmed that since our last inspection in September 2015 that staff had not received any further training and this was a particular concern given the amount of new staff employed in the home.

In addition we saw that at least three people had been admitted into the home that displayed behaviour which may put them or others around them at risk of harm yet no staff had received training in this area. We saw that staff were not skilled or equipped to safely support these people, and there was an inconsistent approach to how staff supported them.

We spoke to one new member of staff who was able to tell us about their recent induction. They said they had spent their first day being introduced to the people living in the home and being shown around the

home and then they had spent a whole week shadowing the head of care, the member of staff said "It felt good."

Since December 2015 no staff had received regular supervision. Staff told us they had received regular supervision up until the last manager left but this had not happened regularly since they had left the service. We saw a timetable for supervisions and appraisals but this finished in December 2015. The staff said they would speak to the head of care if they needed support and would discuss any concerns about people who lived at the home with the RGN on duty. This was not an adequate system of supervision for staff.

This was a breach of Regulation 18 (2) (b) Staffing. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in April 2015 we found that the provider was in breach of Regulation 11: Consent. At our inspection in September 2015 we saw that improvements had been made. At this inspection we saw that mental capacity assessments had been undertaken and where people had been assessed as not having the capacity to make decisions for themselves relatives and other professionals had been involved in making decisions about people's care. However, following a recent admission we found that mental capacity assessments had not been undertaken despite reference to the person being given covert medication. We could also see that a number of DoLS authorisations were due for review and it was unclear as to who was responsible for ensuring these were completed. The instability in the management structure had an impact.

Requires Improvement

Is the service caring?

Our findings

In April 2015 we found that the provider was in breach of Regulation 10: Dignity and Respect. This was because people were not supported to maintain their privacy and dignity and because they lacked basic care and attention. At our inspection in September 2015 we saw significant improvement in the way that people were being cared for.

Prior to this inspection we had received information which suggested that people were not being treated with dignity and respect; people may not be being as well cared for as they had been.

During our inspection im March 2016 people told us they felt well looked after. One person said "I am being looked after very well." Another person said "The staff are very good and look after you when you are ill." The relatives we spoke to also expressed gratitude about the care of their relative. One said "It's lovely here. I can't fault any of the staff; they look after [relative] very well, you wouldn't find a better bunch." Another said "We feel [relative] is generally well looked after and loved." And another said "There have been lots of staff changes but the staff are very good; they are always there."

We observed that people's basic care needs were being met and staff did not rush people as they provided care to them. However, staff did not have the time to spend quality time with people to have meaningful conversations or interactions before they needed to move on to the next person to support. One member of staff commented "We would like to do more." Records indicated people were getting washed each day and their preference to whether they wished to be bathed or showered was recorded; but how often they were able to be bathed or showered was dependent on the availability of staff and not the individual's choice.

We saw some inconsistencies in the way staff spoke to and treated people. We observed staff knocking on doors before they entered a person's room but also observed occasions when they did not knock on the door. Some people's doors were left open; those people who were able to tell us said that is what they wished. However, other people were unable to tell us and there was no indication in their care plans what their preference was which could result in an inconsistent approach. On one occasion we saw that this left a person in partial state of undress exposed to people passing along the corridor. When this was pointed out to staff they attended to the person's needs and ensured their dignity was respected, however this had not initially been identified by staff.

There were some positive interactions with people and people were spoken to politely and discreetly. We heard laughter from one room as staff supported one person with their personal care and staff continually explained what they were doing; as they left the room the person said thank you and the staff responded "You're welcome." However, we observed a member of staff speaking across the lounge to someone questioning their request for assistance and sounding frustrated that they now needed assistance. The staff were stretched trying to meet the needs of everyone in a timely way.

We observed that people were left waiting for the care on numerous occasions throughout the day. An alarm bell rang for over 15 minutes until the staff were able to respond to the person who wanted help to get up.

The staff told us that this person needed two of them to assist them which meant the person was left waiting until two staff members were available. People in their rooms, some of whom could not use their call bell, were left for long periods of time before any staff were able to check on them or assist them with anything. One person had a drink left for them but they were unable to reach it without assistance, and there was little staff support to ensure they had this when they wanted it.

People did appear relaxed and could choose when they wanted to get up and go to bed. One person told us "I had a lay in this morning as I wasn't feeling too well." Relatives told us that they were free to come anytime. One relative said "I can come when I like."

We saw from records that an advocate had been contacted to support a person and there was information about advocacy available to people.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in April 2015 we found that the provider was in breach of Regulation 9 (3) (a) (b) (d): Person-centred care - This was because people were being exposed to the risk of receiving unsafe and inconsistent care following significant staff changes. During the inspection in September 2015 we found that staff were aware of people's individual care needs and that these were consistently being met.

When we inspected in March 2016 we found that pre admission assessments were being carried out by staff who did not have the skills and competencies required. We found that people had been admitted to the home with a history of behaviour which may put themselves or others around them at risk of harm; yet the staffing structures and the home environment was not suitable to safely care for these individuals. We also saw that for at least one new admission that the care plans in place were those that had transferred with the person from their previous placement. These plans were over three months out of date and had not been reviewed or modified to ensure that they were relevant to the person's current needs or circumstances.

Since our inspection in September 2015 there had been a number of staff changes and the current staff team did not have an in-depth understanding of people's needs. We saw that they were reliant on existing risk assessments and care plans. However we found that the risk assessments and care plans in place did not always include all the relevant information that the staff needed to safely support people. For example we were made aware that a person was receiving end of life care, when we read the care plan there was very limited information and staff did not have a comprehensive plan to follow. We asked the head of care to ensure that a more detailed plan was in place and that this was used by staff to ensure that the person consistently received the care that they required.

In another case a relative had told us that their relative was at risk of choking. The RGN on duty confirmed this but we could find no risk assessment or care plan in place to ensure they were supporting the person safely. In the same records we could find no plans in relation to managing the person's diabetes or a plan to ensure the person was well hydrated. With the high turnover of staff and agency staff being used it was essential to make sure that records were kept up to date. The lack of clinical oversight impacted on how safely people could be cared for and their needs fully met.

We spoke to two nurses from an agency about what information was available to them as they came on shift. They told us that they had received a written and verbal handover, however, were in the main reliant on care plans being up to date and speaking to the staff on duty who already knew the person. As the care plans were not accurate or reliable, we observed the RGN's continually seeking information from the care staff about individual people.

Concerns had been expressed from health professionals that risk assessments which had been put in place by the previous manager in relation to people with nursing needs were now being reviewed by staff that had no clinical background. They were also concerned that people were being supported by staff that may have a clinical background but had no knowledge of the staff team or environment of the home. Following our inspection the commissioners of the service carried out reviews of the people living in the home and

concluded that people were at risk of not having their needs safely met. They found that there was poor evidence of pressure area care for people at high risk, advice from other health professionals such as a CPN and dietitian was not being followed and there was a lack of evidence for appropriate monitoring of certain medicines people were prescribed. This was compounded by the lack of a consistent clinical lead and manager.

We observed a number of care practices where people were not being cared for in line with their assessed needs, choices or preferences. People assessed as being at high risk of falls were not receiving the supervision and support they required to maintain their safety. We observed that people did not always receive the supervision or attention that they required or that they had to wait significant periods of time before having their needs met.

In one case a person who had been assessed as having a high risk of developing pressure damage had a care plan in place that stated they should be repositioned every 2 hours. We observed that from 6am to 11.30am the person remained in the same position until the care staff came to change them; and again from 1.30pm to 5.30pm the person remained in the same position. This placed the person at unnecessary risk of developing pressure damage which could ultimately impact on their health. In another situation checks on a person had been regularly recorded but the person had remained in the same position for several hours; when we spoke to the staff about this they said the person did not like to be moved and became difficult when they tried. As there was no overall clinical insight this had not been picked up so that alternative measures could have been put in place. This person was at high risk of developing pressure ulcers.

This was a breach of Regulation 9 (3) (a) (b) (c) Person centred care. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were supported to maintain their faith through visiting clergy who conducted regular 'in house' services. There was an activities programme displayed on the notice board but during our inspection we saw no activities being undertaken by people a part from people being offered a choice of films to watch one afternoon. The staff explained that the activities co-ordinator was on holiday but that there was an expectation that they would do activities in her absence. We read in people's individual care records and there was information that suggested that people were regularly offered the opportunity to take part in group or individual activities. One person told us that sometimes people came to sing and play music and they could take part if they wanted to. In the absence of the activities co-ordinator, people were not supported to participate in activities they enjoyed.

Following the last inspection in April 2015 the provider had revised the complaints policy and we could see that complaints had been recorded and responded to in a timely way. We could see that following a recent complaint that the outcome was clearly available to staff to ensure that the incident did not happen again for the individual concerned. An audit of complaints had been put in place however since December no audit had occurred so there was no evidence to show how the information from complaints could be used to drive improvement.

Inadequate

Is the service well-led?

Our findings

At our inspection in April 2015 we found that the provider was in breach of Regulation 17: Good governance. This was because of significant multiple failings in the management of the service, which had resulted in people not receiving safe care and proper treatment. Our concerns were so great that we rated the home as inadequate and as a result placed it in special measures.

The home was inspected again in September 2015 and found to have made significant improvements. There were systems in place to monitor the performance of the service and identify where improvements could be made.

Since the inspection in September 2015, the manager had left which had a huge impact on the running of the home. Despite feedback from commissioners of the service about the escalating risk factors in relation to the safety of care and support being provided to people living in the home, the provider failed to take any action to mitigate these risks. This failure has resulted in a collapse of the managerial and operational leadership and oversight of the home. During this inspection we found that regulatory requirements were no longer being met.

Staffing levels and competencies were insufficient to safely care for people and adequately meet their needs. The previous manager used a dependency tool which identified people's needs and the level of support they required. This had helped calculate suitable staffing levels but was no longer being used. We found that people were not always receiving the level of care and support they needed and were having to wait long periods of time for interaction or repositioning.

Staff support and supervision structures had not been maintained at the standard that we had observed at our inspection in September 2015. Staff were no longer receiving regular supervision and no further staff training had been planned. The provider had agreed to admit people who had a history of behaviour that could be difficult to manage and no provision had been put in place to equip the staff to manage and support people properly. No one on the current staff team had any up to date training in managing behaviour which could put themselves or other people at risk and we saw that the care offered to some of these people was overly restrictive.

Quality assurance and auditing processes had not been undertaken since December 2015 when the previous manager left the home. Therefore the provider did not have the systems or processes in place to monitor what was happening in the home or to identify the short comings and regulatory breaches identified in this report. Risk assessments and care plans could not be relied upon to provide staff with the direction and guidance they needed. This coupled with the fact that many staff were new or agency staff meant that people living at the home were exposed to unnecessary risk.

The provider had failed to maintain a consistent management structure and relied on different nurses, some agency, to undertake the clinical lead without having the knowledge or ability to have an overview of the service. We had previously instructed the provider that to ensure that people's physical health needs were

being adequately monitored they needed to ensure that there was an RGN on each shift. This had been reiterated to the provider at the September 2015 inspection and we found during this inspection it had not been happening and the person who had recently been appointed as the acting manager was unaware of this requirement. This meant that the provider was failing to provide a safe environment for people in receipt of nursing care and satisfactory action had not been taken to address or mitigate these risks. Records in the home could not be relied upon as accurate accounts of people's needs or of the care and support offered to people. Audit systems had again not identified or addressed these failings and staff were in the main reliant on word of mouth to update each other on the care and support requirements of people in the home.

During our inspection we saw that there was sufficient food supplies in the home however we had growing concerns about the financial status of the provider. Staff talked to us about confusion over their wages. Some staff had not been paid on time and others were owed money from the provider. We noticed that the clinical waste bins had not been emptied and were overflowing. When we asked about this we were told that the provider had not paid the bill and until they did the bins would not be emptied. A tumble dryer had a notice (dated 10 March 2016) on it not to be used. We were told there had been confusion between the installer and British Gas as to whether it was safe to use due to a ventilation issue. It was left to the maintenance person to sort out, which they did during the inspection.

There was a lack of contingency planning in place and it appeared to be the expectation from the provider that the staff, without a manager in place, or access to finances, could deal with issues associated with the running of a home. During the inspection there was a problem with the cooker and the gas supply had to be switched off. The head of care and maintenance person were left to deal with it but were unclear what to do and sought advice from the inspection team and another health professional who was visiting the home at the time. Although the staff had contacted the provider they were left to sort things out; it was fortunate that the gas supply went back on during the day as otherwise the home would have been left without heating during the night and there was no contingency in place to ensure people were kept warm.

This was a breach of Regulation 17 Good governance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff morale was low as staff seemed unclear as to who was managing the home and felt under pressure to meet the needs of the people living at the home with so few of them. One member of staff said "We want to do more for people." Individual staff were committed to providing good care for people but there was not enough of them to consistently do so. They lacked the support and guidance from management.

We were told that whilst an acting manager was on annual leave, a nurse from an agency was acting as the clinical lead. The nurse left whilst the acting manager was away which left only the head of care that had no clinical or professional qualifications in charge. There was no consistency and the head of care was also expected to stay on rota to provide care for people in addition to the extra responsibilities they were undertaking. Although we were told that the provider visited the home once a week there was little evidence to support this and some staff were unable to confirm that this was the case.

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 The provider failed to ensure that people had access to other health professionals when advised to do so. Reg 9(3)(c) The provider failed to ensure that the care and treatment people were receiving was the most appropriate, met their needs or reflected their preferences. Reg 9 (3) (a) (b) (c)

The enforcement action we took:

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risk assessments were kept up to date and were being reviewed by staff who had the necessary qualifications, skills, competency and experience to do so. Reg 12(2)(a) The provider had failed to ensure that the staff responsible for the management and administration of medication were suitably trained and competent and were following policies and procedures Reg 12(2)(g)

The enforcement action we took:

We imposed conditions on the provider's registration to prevent any further admissions and placedthe service in special measures

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure that nutritional and

	hydration needs of service users were met. Regulation 14 (1)

The enforcement action we took:

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain systems to assess, monitor and improve the quality and safety of the services. Regulation 17 (2)(a) The provider failed to maintain systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 (2)(b) The provider failed to ensure that records kept were accurate and up to date. Regulation 17(2)(c) The provider failed to ensure that audit and governance systems were maintained and effective Reg 17(2)(f)

The enforcement action we took:

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's assessed needs. Regulation 18 (1) The provider did not support staff to obtain appropriate further qualifications that would enable them to continue to perform their role. Reg 18(2)(b)

The enforcement action we took:

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.