Mr Seamus Patrick Flood

Shannon Court Care Centre

Inspection report

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Date of inspection visit:
20 July 2016

Date of publication:
05 September 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The unannounced inspection took place on 20 July 2016. At the last inspection on 13 January 2016 the service was meeting all requirements.

Shannon Court Care Centre provides general nursing, dementia nursing and dementia residential care. The home can accommodate up to 78 people in single rooms, most of which are en-suite. On the day of the inspection there were 75 people currently using the service.

There was a registered manager at the service. 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.

However, at the time of the inspection the registered manager had been on sick leave for a period of approximately two months and had recently handed in her notice. The service was being managed in her absence by two deputy managers. The provider had identified someone who would register as manager in the near future.

During this inspection we found multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 with regard to person centred care, dignity and respect, consent, safe care and treatment, safeguarding, meeting nutritional and hydration needs, good governance and staffing.

You can see what action we told the provider to take at the back of the full version of the report.

On observing the premises we found them to be extremely dirty and untidy with a number of cross infection risks apparent. There was an outside roof patio overlooking the car park with a low wall which people who used the service could have fallen or climbed over, suffering significant harm or injury.

The service had a robust recruitment procedure in place to help ensure people being employed were suitable to work with vulnerable people. Staff rotas and observations on the day showed that staffing levels were insufficient to meet the needs of the people who used the service.

Individual and general risk assessments were in place. However some of the monthly evaluations of individual risk assessments were not up to date. Medicines were not managed safely at the service, as we saw evidence of unsafe administration, storage and disposal of medication throughout the day.

Notifications of serious injuries had not been submitted to the CQC as required over the last 12 months.

There was a safeguarding policy in place but staff knowledge and understanding was basic and safeguarding incidents had not always been reported as required.

In looking at staff files we saw that the service's induction was basic and there was no evidence of staff supervisions or appraisals for the last 12 months. There had been little training given to staff over the last year.

Information in people's care files was inconsistent in quality and content. Consent forms for the use of photographs were present within files but were not signed.

There was little choice with regard to meals and we saw that people were not being assisted with nutrition and hydration. Dietary requirements were documented inconsistently.

The environment was not dementia friendly and had little in the way of signage to help with orientation or distinctions between doors and the floor to help people distinguish between them.

The service was not working within the legal requirements of the Mental Capacity Act (2005) (MCA).

We saw that people who used the service were poorly presented. People's privacy and dignity was not always respected by staff delivering care. There was no evidence that people who used the service, or their relatives where appropriate, were involved in care planning and reviews. We saw some evidence that the service had engaged with people to help ensure their end of life wishes were known.

There was some evidence that people's choices were respected, for example, times they wished to get up or go to bed. However, care plans were inconsistent in including information about personal preferences, backgrounds, likes and dislikes. There was evidence that some activities took place regularly but we saw no meaningful one to one interactions occurring between staff and people who used the service.

There was an appropriate complaints policy, which was displayed around the home. There had been no complaints in the previous 12 months.

The service had poor leadership as, in the absence of the registered manager, those in charge were lacking in authority and experience. Team meetings had not been held for the last 12 months.
Quality audits were ineffective as there was little evidence of follow up to address concerns and issues identified.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
•□Ensure that providers found to be providing inadequate care significantly improve
•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
•□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's

registration.

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.

The premises were not clean and there were a number of cross infection risks observed. The outside areas were at risk of being unsafe.

The service had a robust recruitment procedure to help ensure people being employed were suitable to work with vulnerable people.

Staffing levels were insufficient to meet the needs of the people who used the service.

Medicines were not managed safely at the service and safeguarding issues had not always been reported as required.

Is the service effective?

Inadequate

The service was not effective.

The service's induction was basic and there was no evidence of staff supervisions or appraisals for the last 12 months. There had been little training given to staff over the last year.

Information in people's care files was inconsistent in quality and content and consent forms were not signed.

People were not being assisted with nutrition and hydration. Dietary requirements were documented inconsistently.

The environment had little in the way of signage to help with orientation.

The service was not working within the legal requirements of the Mental Capacity Act (2005) (MCA).

Is the service caring?

Inadequate

The service was not caring.

People who used the service were poorly presented.

People's privacy and dignity was not always respected by staff delivering care.

There was no evidence that people who used the service, or their relatives where appropriate, were involved in care planning and reviews.

We saw some evidence that the service had engaged with people to help ensure their end of life wishes were known.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was some evidence that people's choices were respected but care plans were inconsistent in including information about personal preferences, backgrounds, likes and dislikes.

There was evidence that some activities took place regularly but we saw no meaningful one to one interactions occurring between staff and people who used the service.

There was an appropriate complaints policy, which was displayed around the home. There had been no complaints in the previous 12 months.

Is the service well-led?

Inadequate

The service was not well-led.

The service had poor leadership as, in the absence of the registered manager, those in charge were lacking in authority and experience.

Team meetings had not been held for the last 12 months.

Quality audits were ineffective as there was little evidence of follow up to address concerns and issues identified.

Shannon Court Care Centre

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.

The unannounced inspection took place on 20 July 2016. The inspection team consisted of four adult social care inspectors from the Care Quality Commission (CQC).

Before this inspection we reviewed the previous inspection reports and notifications that we received from the service. We contacted the local authority commissioners of the service and the Clinical Commissioning Group (CCG) to seek their views about the home.

Prior to the inspection we had received a number of whistle blowing concerns regarding alleged poor care and treatment of people who used the service.

During the inspection we spoke with a professional visitor to the service, two relatives, two nurses, eight members of care staff, and the two deputy managers. Some people who used the service were unable to tell us their views as they were living with varying levels and types of dementia. However, we spoke with people who used the service as we observed care throughout the home during the day.

During the inspection we looked at eight care files and food and fluid charts, undertook pathway tracking of two people's care records, which involves cross referencing care records via the home's documentation. We also looked at five service user activities files, six staff files, training records, policies and procedures, staff rotas, meeting minutes, Medicines Administration Records (MAR) and quality audits.

Inadequate

Is the service safe?

Our findings

We asked a visiting relative if they thought the home was safe. They told us, "I would say it's a safe place for my [relative]. When I visit, I have never seen anything that has worried me".

On arrival the home presented well, the reception area was clean and tidy. We walked around the premises at approximately 7 am, shortly after we arrived at the home. We found that the general condition of the home was dirty and very untidy. Some corridors we walked down had plastic covering half way up the walls, which one of the deputy managers told us was to stop wheelchairs scuffing the paintwork. This gave an institutional look and feel to the home.

In the corridors we saw items, such as a packet of wet wipes on the floor. We saw a number of hairbrushes placed on top of fire alarm boxes, in bathrooms and on top of cupboards. There were linen cupboards and store rooms, where doors should have been kept closed as per fire regulations, which were open despite there being notices on the door to remind staff. On looking inside the rooms were messy and untidy and we saw a rusty toilet frame in one of the bathrooms and ceiling tiles missing in other places.

One toilet had no door on it. One of the deputy managers told us this had been taken off as the corridor was going to be widened at some point in the future. In a toilet on the dementia residential unit we saw a person's belt hanging over the shower rail. This could have presented a ligature risk so we told staff and they removed it at once. A razor was left on top of a towel in a bedroom and we again alerted staff who removed this immediately. On one stairway we saw a bed frame and two mattresses covered in blue plastic stored, which could have caused a fire hazard.

There was an 'assisted' toilet on one unit where the door was wedged open with a bin containing dirty linen. There was no toilet seat on this toilet. We also saw an open bin in the dining room containing dirty clothes protectors from the morning. There were plastic gloves, used by staff, and continence pads left in bathrooms and on radiators. Plastic laundry bags were also seen in bathrooms. These items could present a suffocation or choking hazard for people who used the service.

There were two buckets in a store room which had dirty water in them. One was yellow – used for isolated areas, and one was blue – used for general areas. We saw some block soaps in bathrooms, which can aid the spread of infection, and where there were liquid soap dispensers some were empty. The home had experienced a recent significant infection outbreak, and had been given support and advice from the infection control team. We saw that a total of 25 staff had undertaken infection control training in October 2015. However, it was apparent from what we saw that the advice and guidance from the infection control team was not being followed at the home. Following the inspection we contacted the infection control team and they carried out an audit at the home. The results of this were poor and the infection control team once again offered support and guidance to the home.

The staff member responsible for domestic tasks began her daily tasks later in the morning, so we walked around the premises again in the afternoon to see if there had been any improvement. However, we found

that the home was still very dirty and untidy. For example, in one of the bedrooms although the bed had been made the toilet had not been flushed and the person whose room it was had had a bowel movement. The person could not have returned to their room after the cleaner had been in, as people who used the service were unable to return to the upper floors without assistance, due to a number of key pad locks on lifts and corridors.

This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was an outside patio area adjacent to the general nursing unit. This area was raised and overlooked the car park. It had a wall which was waist height and people who used the service could have fallen, or climbed, over this wall resulting in harm. We spoke with the provider about this and he agreed to ensure people did not access this area until the risk was mitigated. We also saw that the outside area was untidy, there was an empty plastic bottle on the floor and several pieces of plastic left around the patio.

There was another outside area, in the form of a sensory garden, for people to access. The area was not secure as the home was awaiting some railings to be erected to ensure the area would be enclosed, so staff told us they only brought people out to the sensory garden on a one to one basis at present.

This was a breach of Regulation 12 (2) (d) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at six staff files and saw that the home had a robust and safe recruitment system in place. Files included application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. These checks help ensure potential employees are suitable to work with vulnerable people. Nurses' professional registrations (PIN numbers) were checked and were all up to date.

We looked at staffing levels and saw that, on days, there were two deputy managers working the same shifts (Monday to Friday). Consideration could be given to whether this was the best way to deploy the deputies as there was no manager present at weekends or on nights.

On the day of the inspection, on the dementia nursing unit (29 people using the service) there was one nurse and five carers in the morning and four carers in the afternoon. On the general nursing unit (18 people using the service) there was one nurse and two carers and on the dementia residential unit (28 people using the service) there was one senior and four carers. We were told by the deputies that sometimes there was only one nurse on duty. On nights there was either one nurse and eight carers or two nurses and 6.5 carers. There were also one or two domestic staff, an activities coordinator, therapist, laundry staff and a maintenance worker. This was confirmed by recent rotas we looked at.

We did not see any evidence of a dependency tool within people's care plans, to inform staffing levels. We saw that one person needed the support of three carers for all interventions and this meant staffing levels were insufficient to meet the needs of the people who used the service. A dependency tool, outlining each person's level of dependency, would help to ensure enough staff were on duty to meet people's needs.

One staff member we spoke with said, "We definitely need more staff on this unit. There are a lot of accidents and lounge areas always seem to be left unattended, which makes monitoring people difficult". Another told us, "I think we are short staffed on this unit. Sometimes there will be three care staff plus a nurse, but other times there might only be two. It's a struggle to care for people in bed and keep an eye on people in lounge areas". A third staff member commented, "I do work across different floors. There always

seems to be enough staff around whenever I am on shift. No concerns from my point of view". One member of night staff we spoke with told us they felt staffing levels on nights were sufficient to meet people's needs. They told us some people liked to get up early and staff were able to accommodate this wish and assist with people's personal care as they got up gradually.

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

There were individual risk assessments in people's care files. These were to be evaluated on a monthly basis but we found that some had been evaluated and were up to date; others had not been reviewed for two or three months. Personal Emergency Evacuation Plans (PEEPS), which outline the level of assistance that would be required in the event of an emergency, were present in people's files. However, there was no 'grab' file on reception for the staff to give to fire personnel in the event of a fire breaking out. We spoke with one of the deputy managers about this and she agreed to implement a 'grab' file straight away.

The home used the bio dose system for administering medicines. This is where medicines are contained in a 'pod'. Each pod can contain tablets or liquid medication. This helped ensure medicines in the pods were administered safely. However, medicines supplied separately, in boxes, such as medicines used as and when required (PRN) and topical creams were a concern.

We saw a number of topical creams in people's bedrooms and in bathrooms. Some of these creams had names on them, others did not. Some had instructions for applications, others had no instructions. There were also some creams, used for the treatment of eczema or dermatitis, in plastic drawers in the dining room on the general nursing unit and these drawers were unlocked and also contained Alendronic acid, used to treat osteoporosis, was also stored in these drawers.
On top of the drugs trolley, stored in this room, was a jug of juice, uncovered, and a blue kidney dish with eye drops, dated 11/07/16 which stated they should be stored in the fridge. There was also a box of Gaviscon with no name on it.

We looked at the medicines room on the dementia nursing unit and saw that it was untidy and the drugs trolley and controlled drugs cupboard was dirty. There were a significant number of unlabelled creams, some of which were out of date. The nurse told us some of these were for people who were now deceased. The window of this room was wide open, leaving it accessible to people from outside.

We saw two tins of thick and easy thickener under the sink in the kitchen on the dementia nursing unit. These were not labelled with anyone's name or instructions on the consistency to make the liquid to. Staff we spoke with were unclear about who was prescribed thick and easy. This meant people were at risk of choking if they were not given thickened liquids made to the correct consistency.

We observed a medicines round in the afternoon and saw that the nurse on duty left the drugs trolley open and unlocked on two occasions, people were mobile and seated nearby. This could have resulted in a person who used the service accessing the drugs in the trolley. We also looked at six medication administration record (MAR) sheets, all of which had a photograph of the person the sheet related to. We saw that the nurse had signed some of the MAR sheets prior to giving the medicines. She signed for four medicines between 3.50 pm and 4 00 pm, some of which were not due to be given until 9 pm. These medicines included Warfarin, and this could have had serious consequences, for example, if the nurse on duty later in the day had thought these drugs had been given, due to the signature on the MAR sheet, and had not therefore administered them as required. When asked about this the nurse said it was an error on her part.

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

We saw a number of audits undertaken in June 2016, such as a dining room audit and a care plan audit. Overall these audits seemed to report positive findings, which was not what we observed on the day. A recent medication audit had been carried out and identified actions to be taken around issues picked up within the audit.

Accidents and incidents were recorded in an accident book; some of these incidents were minor. However we saw no evidence of follow up to accidents, such as the acquiring of safety equipment or referral to the falls team, and no required notifications to the Care Quality Commission (CQC) of more serious accidents. For example where head injuries or possible fractures had been sustained. There was also no evidence that the monitoring of accidents had identified the fact that some people had sustained numerous falls, which we saw was applicable to at least three people currently using the service. We are following this up outside the inspection process.

There was an up to date safeguarding policy and procedure at the home, though this was not being followed appropriately in making referrals. Staff spoken with demonstrated a very basic knowledge of safeguarding issues and reporting procedures. One staff member said their training had been carried out "a while ago".

One person who used the service had sustained bruising to their face but there was no record of how or when this had happened. The staff had recorded when it was noticed, but no one had been able to explain the incident that caused this bruising. We asked if this person had been observed following the incident, but there were no records of observations. The GP had not been called to look at the bruises and the incident had not been referred to the local authority safeguarding team, nor were CQC notified. This was referred by CQC to safeguarding, who will look into this, and a GP was called out subsequently to check the person over.

This was a breach of Regulation 13 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service had a whistle blowing policy in place and staff were confident in how to use this. However, one staff member said they were worried about confidentiality if an issue was raised about another staff member, as they felt staff discussed other people's issues day to day.

The service used CCTV in external areas of the home. This needed to be added to the Statement of Purpose to ensure potential users of the service, visitors and relatives were aware of the use of CCTV.

Medicines policies and health and safety policies were all in place and up to date. Health and safety systems were in place at the home. Maintenance and service records were complete and up to date. Gas and electrical safety certificates were in place and equipment such as lifts, hoists, fire equipment and alarms had been serviced as required. Issues such as regular water temperature tests and legionella sample testing had been undertaken regularly. We saw that a number of staff had completed fire awareness training in October 2015.

Inadequate

Is the service effective?

Our findings

We asked staff about their roles and responsibilities at the home. One staff member said, "It is going good since I started working here. I enjoy the different challenges that the job entails". Another told us, "I've recently handed my notice in. I'm not happy here anymore and I am looking to move elsewhere. I don't like the care that is given to people here". A third staff member commented, "It is not as good at the minute compared to when I first started".

We looked at the staff files but saw little evidence of staff induction, though staff told us they had been required to read relevant policies and sign to say these had been read. One staff member had started as a domestic and changed their role to carer without any induction into the new role. One staff member told us, "I did an induction but it wasn't the best I must say. I wasn't provided with any training by the home, so luckily I had worked in care previously. I haven't been informed when I will be doing it either". Another said, "I did have an induction, but it wasn't very thorough. I had a quick tour around the building, read a few policies and procedures and that was about it".

We found no records of any recent staff supervisions. These provide an opportunity for staff to raise any issues and for management to monitor performance issues and facilitate discussions around training and development. We asked both deputy managers about their understanding of supervision and they had no knowledge of what this was. We spoke with staff about supervisions and one person said, "I've not had one yet and I know a few other members of staff who have said the same". Another told us, "There seems to be an inconsistency with them. I haven't had one for ages though". A third staff member said, "I used to have them when I first started, but I can't remember when my last one was". Two other staff members told us they were content without formal supervision sessions as they could approach the seniors if they needed to.

From the training records we saw it was apparent that there had been few training courses over the last year. Staff confirmed they had not had training for some time. One staff member said, "I've had nothing formal since being here. I haven't done anything around safeguarding, moving and handling, infection control and MCA/DoLS". Another commented, "We don't get enough training here. I wasn't happy with the moving and handling training I got and it was lacking in detail". A third person said, "I've not done anything for well over a year now and that seems to have really dropped off. There were no training updates done under the previous manager. It's been raised with the owner but he seems to shrug it off".

Other than the fire awareness and infection control training 13 members of staff had undertaken training in moving and handling in September 2015 and eight staff had undertaken managing challenging behaviour training in October 2015. There was a training matrix on the wall in the basement of the building, where the offices were situated, but one of the deputy managers told us this was out of date. We saw no evidence of any dementia training even though the people who used the service were living with a wide range of dementia conditions and were at different stages in the progress of the condition.

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

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There was an up to date policy and procedure for MCA and DoLS. We saw little evidence in the care files we looked at of the MCA being applied to decision making or best interests decisions being made in accordance with the MCA. Staff had little knowledge of MCA. One staff member said, "I think I've done DoLS training but not MCA training and I'm not sure what this is about".

There were 62 people at the home who were subject to a DoLS authorisation. The paperwork for these authorisations was complete within people's care files and there was a master file which included all the dates of applications, authorisations and review/renewals. This was up to date and all complete. However, staff we spoke with demonstrated little understanding of what DoLS meant for people in terms of exercising the least restrictive methods to keep people safe. One staff member said, "I'm not sure what this is about and I'm not sure who else has done the training. I wouldn't know if anyone was on a DoLS".

There were consent forms kept within care files relating to the use of photographs within the home to place on MAR sheets and in activity files. These were not dated or signed and there was no reference to the individual's capacity to understand or consent to photographs being taken and used. There were no discussions with relatives recorded and no use of advocates to speak for individuals to ensure their best interests were being represented.

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

There was a policy and procedure in place relating to nutrition and food safety. The home had a 5 star rating from food hygiene standards displayed in the home. This was dated 27 July 2013. The day's menu was displayed on a menu board in the dining room of the dementia nursing unit, with pictorial representations, though the pictures were of poor quality and it was difficult to recognise what the food was.

We asked a visiting relative what they thought of the food at the home. They told us, "My [relative] seems to enjoy the food and always seems to be eating different foods. It looks fresh and smells good".

There was porridge or cereal, toast and marmalade for breakfast, soup and sandwiches or vegetable broth and cake and custard for lunch and fishcakes, mashed potato and peas followed by angel delight for evening meal. Staff told us supper consisted of cereals and toast. We did not see anyone have a cooked breakfast on the day of the inspection and the choices at lunchtime were very similar. There was no choice offered at the evening meal. We observed the lunchtime meal for some time. There were no coloured plates to help people living with dementia distinguish the food and there was a lack of finger foods, which would be more appropriate for people at the home. These measures are recommended as good practice in dementia care. No condiments were set on the tables and there were no table cloths to make the dining experience more pleasant. Staff missed numerous opportunities to assist people with their meals. Drinks

were served in plastic coloured cups and beakers, which were not dignified or age appropriate. No hydration stations were observed around the home so people who used the service could access drinks at any time.

One person asked if they could have porridge for their lunch and they were told, quite abruptly by a member of staff, "There's no porridge at this time". The person asked why and were told, "Good question". Later the porridge was brought for the individual who ate and enjoyed it.

One person's care plan stated that they had a nut allergy. However, there was no guidance for staff as to how this may present or how they should deal with this should it occur. This could have resulted in the person suffering unnecessary discomfort. Another person's care plan stated they should be given a soft diet, however, in the kitchen this diet was documented as pureed. It was unclear which diet the person should be having, which could have caused the person to be at risk of choking if given the wrong diet.

Some files included contradictory information, for example, in one care plan the nutritional assessment indicated that the individual had an issue with weight loss and this needed to be monitored. However, the Malnutrition Universal Screening Tool (MUST) stated that the person had a healthy weight and there was no concern. Weights were recorded for May, June and July 2016 and were very similar. However June's weight was described as normal while July's weight, which was a little higher, was described as underweight. An evaluation on 16 July 2016 stated that this person had lost 9 kg since the last evaluation but this did not tally with other records within the file. This person was also described as at high risk of falls and they had experienced ten falls in June. The records stated that the GP would refer to the falls team but it was unclear if this had been done.

Food and fluid charts were filled in for people who used the service. These had been completed for most days but there were odd days where the charts were missing, with no explanations as to why this was the case.

We did not see staff encouraging or assisting people to eat their meals. Three people sitting in the conservatory at lunchtime were asleep and were not being prompted to eat their food. At 2 pm we saw that an individual sitting in the conservatory still had their lunch of sandwiches in front of them along with cake and cold custard and two plastic beakers of tea. None of this food and drink had been touched and had been there for approximately two hours.

This was a breach of Regulation 14 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff referred to different areas of the home by different names, for example Unit 1, Unit 2, Lantern area, red, pink, orange and blue areas, dementia residential, dementia nursing and general nursing unit. This could be very confusing for the majority of people who were living at the home who were living with dementia.

Some people were still in bed when we walked around the home at approximately 6.45 am. Staff told us that they were given the choice of what time they wanted to get up. The environment was difficult to navigate around due to the care home being spread over different floors with key pad locks on lifts and corridors. Orientation was particularly hard as there was no signage to help people find their way around. This meant that once people on the upper floor were up and were taken downstairs to the communal lounge, they had no choice about returning to their room later in the day if they wanted to. This meant their liberty of movement was restricted.

This was a breach of Regulation 13 (4) of the Health and Social Care Act (Regulated Activities) Regulations

2014.

On the general nursing area there was a small dining area with one small table which had three chairs around it. The room also contained two large chairs, some plastic drawers and the drugs trolley. This meant people who used the service were not able to use the dining room and meals were served to them in the lounge area. In the conservatory area we saw food under the radiator and down the sides of one of the arm chairs.

Outside there was a new addition of a sensory garden. This contained lots of herbs, pots, bird feeders, pottery animals and a beach area. The garden offered lots of aromatic smells, tactile areas and colour. However, on the day of the inspection, which was a lovely sunny day, no one was accompanied outside to enjoy this area. We asked a member of staff why no one was using this area and they replied, "It's usually the case, they [staff] don't bother".

Inadequate

Is the service caring?

Our findings

We spoke with a visiting relative about the care given at the home. They told us, "Overall it's excellent as far as I can see. I think the care here is good. I've no concerns at all; my [relative] is very well looked after. Things are going very well". When asked about staff they said, "All in all, they have been very good indeed. They seem good at their jobs and my [relative] seems to like them".

We asked staff about how they respected people's privacy and dignity. One staff member said, "I'll ask if people want me to stay in the toilet with them [or leave them] to give them privacy. I treat people the way I would like to be treated". Another told us, "I'll always close doors if people are getting changed in their bedroom and covered when they get out of the shower. I make sure people get what they want out of respect". A third staff member commented, "I'll close curtains during personal care and make sure people's teeth are cleaned properly so there breath is fresh if they can't do it themselves".

Despite staff being able to tell us how dignity and privacy were respected we observed instances where people's dignity was compromised. We saw one person being seated in a very dirty armchair by staff. This individual was living with dementia and may have been unable to understand that the chair was dirty or articulate a wish to sit elsewhere. They were, therefore dependent on staff to ensure their dignity was preserved. On another occasion we observed an individual in their bedroom with two health professionals present. This person was not wearing any trousers and staff made no attempt to cover them. This was challenged by the CQC inspector and pyjama bottoms were eventually put on, approximately 10 – 15 minutes later.

This was a breach of Regulation 13 (4) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed throughout the day that people who used the service were not well presented. Some people's nails were dirty and some gentlemen were not clean shaven. Sinks in some people's bedrooms had no plugs and were cracked.

Clothes protectors were put on people at meal times without asking whether they wanted them or explaining what they were for. Six people in the conservatory area were not wearing any socks or shoes. When asked about the reason for one individual being without socks and shoes a member of staff said, "I think the socks make her legs itch, she takes them off". There had been no thought to providing an alternative, such as ankle socks and/or slippers to keep the person's feet warm. There was also a risk of infection or tripping and falling. Staff confirmed that this had not been risk assessed. A team of health care professionals from the Clinical Commissioning Group (CCG) subsequently visited the home and found the same situation. One person who was wearing no shoes and socks had extremely dirty feet and staff were asked to remedy this straight away. However this had not been done when the CCG left the home three hours later.

On walking around the home and looking at people's rooms we saw no evidence of oral hygiene. We did not

see any toothpaste, only one toothbrush and no mouth wash. When asked about oral hygiene staff were unable to explain how this was administered. We asked one member of staff how they assisted one person with oral hygiene and were told, "They've got no teeth". A lack of regular oral hygiene may compromise people's health and well-being as well as demonstrating a lack of basic care and attention to people's dignity.

This was a breach of Regulation 10 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked staff how they promoted people's independence. One staff member told us, "If I'm assisting somebody to eat, I will let them have a go at eating themselves first. If I know somebody can walk then I wouldn't offer them a wheelchair". A second member of staff said, "One person constantly asks for a wheelchair but I know they can walk so I support them to do that instead". A third said, "If I'm supporting people to have a drink I will let them hold the cup and have a go first. It's important they retain as much independence as possible". However, we observed people at meal time struggling to eat, or making no attempt to eat, and little encouragement or support was offered by staff.

We observed care during the day and saw that there was little meaningful interaction between staff members and people who used the service. Most people spent the day sitting in a chair, largely unengaged in any activity or form of interaction.

We did not see evidence within care plans of people who used the service, or their relatives, having involvement in their care planning and reviews. We asked a visiting relative if they had been involved with their loved one's care plan. They told us, "I can't say they have ever gone through it with me or invited me to discuss anything". Neither did we see any reference to advocates to represent people's views and best interests.

A residents'/relatives' survey had been sent out in July 2016. The residents' survey included questions about whether people were happy living at Shannon Court and with the laundry service, if they liked the menus and activities provided by the home. Residents were asked what the home could improve on and what they felt the home were good at. It is unclear how people who used the service would answer this as they were living with dementia and, from our observations of them, would struggle to articulate their views. The relatives were asked similar questions about the service, whether they were kept informed of changes or when their relative was unwell and if they felt involved with care plans. The responses to these surveys had not yet been received and collated by the service.

We saw some good advance care planning documents within files which outlined people's preferred place to be when they were nearing the end of their life. These had been discussed with relatives where appropriate and were detailed and informative. However, some we saw were not signed or dated.

Requires Improvement

Is the service responsive?

Our findings

We saw that people's rooms had been personalised with their own photographs and ornaments. Some people's rooms had a memory box outside the door with photographs and memorabilia in them. However, many rooms did not have this and there were no names on doors to identify people's bedrooms. There were no pictures on the corridor walls to supply interest or aid reminiscence.

We looked at eight care plans. These included a booklet entitled 'All About Me' but these booklets were inconsistently completed. There was information around family history, preferred food and drinks, things that made the person happy or frightened, things the individual enjoyed, religious beliefs, special diets, activities and hobbies, work history. They did not include preferences with regard to sleeping pattern, times of rising and retiring. Some of these had been fully completed but others were blank or had sections about living at the home that had not been completed. We saw documentation of handovers from staff on one shift to another. These were poor and contained little meaningful information.

The care files contained a range of health and personal information. There was a comprehensive baseline assessment, which covered all aspects of care and support needs, completed when people were admitted to the home. The quality of the information after this was inconsistent from file to file as well as within some of the files. There were risk assessments for areas such as falls, absconding, moving and handling and nutrition. Some files contained records of monthly reviews of risk assessments and care plans which were up to date. However, in other files it was clear that reviews had not been carried out on for a period of two or three months prior to the inspection.

In another care file an individual had been identified as at risk with regard to skin integrity. The chart was incomplete and the part referring to equipment required was not filled in. There was no documentation to demonstrate any follow up actions around the individual's high level of risk in this area.

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

We saw a number of activities advertised around the home, such as armchair exercises, communion, coffee afternoon, summer fair, sensory garden and entertainment. The Shannon newsletter provided an overview of events that had occurred at the home. These included Lion Learners, when animals had been brought into the home and people encouraged to interact with them. There had also been a picnic and singer to celebrate the Queen's 90th birthday. Upcoming events included bingo, holy communion, singers and entertainers and armchair exercises.

A singer, who was a regular entertainer at the home, visited in the afternoon to provide some entertainment for some of the people who used the service. However we did not see any one to one interactions or activities happening on the inspection day, such as staff reading newspapers with people, chatting meaningfully, providing hand and nail care, taking people for a walk in the garden or doing jig saws and playing games. There were no tactile items inside the home for people to make use of.

We looked at six activities care plans which contained photographs of people taking part in various activities. These included pictures of a visit with animals in June 2016, a day out to a local fish and chip restaurant and a Zumba disco.

The home had an appropriate, up to date complaints policy. This was displayed in various areas around the home. We asked a visiting relative if they had ever made a complaint. They told us, "I've never needed to make one but have seen the procedure displayed on the wall". We looked at the complaints book but there had been no recent complaints made.

Inadequate

Is the service well-led?

Our findings

There was a registered manager at the service. 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. However, at the time of the inspection the registered manager had been on sick leave for a period of approximately two months and had recently handed in her notice. The service was being managed in her absence by two deputy managers. The provider had identified someone who would register as manager in the near future.

We asked a visiting relative about the management at the home. They told us, "I haven't had much interaction with the deputy managers. They seem nice enough though".

We spoke with staff about how they found the management at the service. One staff member said, "The deputies seem to be in charge at the minute. They seem to be there if you need them. I feel I can speak to them and they seem approachable". Another told us, "None of us know what is going on with the manager and it's important that we do. I'm not happy with the situation at the minute".
A third staff member commented, "It's [management] none existent at the minute".

Through observations throughout the day we saw that the deputy managers were lacking skills, confidence and experience regarding the management of staff. This was confirmed by the local authority safeguarding team who had asked the deputy managers to direct some members of staff to make statements about an incident. When asked if this had been done they replied that they had asked, but staff had not supplied the statements. This demonstrated their lack of authority when dealing with staff members. The deputies also told us they felt ill equipped to question clinical issues as neither of them were qualified nurses. This meant the nursing staff were lacking direction and motivation via strong management and leadership.

When asked if they felt valued a staff member said, "I feel I am recognised and I think we are valued but there's not enough hours in the day sometimes." Another told us, "I feel that if there was a problem I could raise it and would be listened to."

We asked about staff team meetings, and one of the deputy managers told us there had not been any recent meetings. One staff member said, "I've never been involved in one since I have worked here". We saw from staff records that supervisions and staff appraisals had not been undertaken for the last 12 months. One staff member told us that staff were frequently moved around to different units, but they felt staff worked quite well as a team. Another said, "I feel the staff get on well and work well together. We help each other out and the manager is always available on day shifts."

There was an up to date policy for Quality Management at the service. We saw that a number of audits were being carried out regularly, for example, there had been several audits undertaken in June 2016, including activities, dining room experience, care plans and medication. The activity audit covered a sample of people who used the service and asked whether people had a life history in place, a memory box; activities

participated in, introduction to new activities and any difficulties. The dining room audit looked at whether the dining room was clean and tidy, if pureed diets were being provided, whether enough staff were available to support people and if meals were nicely presented. It also looked at whether staff were wearing appropriate personal protective equipment (PPE). The care plan audit focused on whether documents were in chronological order, if an admission assessment had been completed, Waterlow assessment completed, all appropriate risk assessments were completed and if the care plan was person centred. Actions to be taken were identified. The medication audit covered areas such as completion of MAR sheets, whether allergies were recorded, issues around controlled drugs, fridge temperatures, carry over tallies, reasons for missed medications and homely remedies. This audit again identified any actions to be taken.

We found that although audits were being undertaken what we observed on the day indicated that these were not meaningful and actions had not been followed up. There was little evidence that activities were person centred as we did not see any staff interacting on a one to one basis with people living with dementia. Care plans we looked at were inconsistent in content and quality and not all monthly evaluations were complete and up to date. We found a number of issues with medicines management that demonstrated that the medicines audit was not effective.

Similarly, although accidents and incidents reports were monitored monthly, there was no evidence of what action had been taken or whether any trends or patterns had been identified. For example, this monitoring had failed to pick up on people who were having multiple falls and what was being done in response to this.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act (Regulated Activities) Regulations 2014 regarding good governance.