Parkcare Homes Limited

# Preston Private

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

We inspected this service on the 10, 11 and 12 February 2016. The first day of the inspection was unannounced. The home was last inspected on 20 July 2015 where four breaches of the regulations were found. At this inspection we looked to see what work had been completed to ensure the quality and safety of the service had improved. The provider had told us in their action plans they would have completed all the action required to meet the regulations in April 2016. We found there was still some work to be done and would re-inspect the service when the deadline had passed to ensure the service had improved.

The service is a large building that can support up to 105 people. Support at the home is split into three categories. There is one unit specifically supporting people living with dementia. One unit supporting people with residential care needs and two units supporting people with nursing needs. At the time of the inspection there were 92 people living in the home.

The home has a number of corridors. The main entrance leads into a small reception area and administration office. From this area you walk onto a wide corridor at a 'T' junction. One way leads down to the dementia unit which is a stand-alone unit and the residential unit. The other leads to the two nursing units. The residential unit and one of the nursing units also join at the other end of the building. A number of smaller corridors interlink units. It is very easy to get lost in the home and whilst each has a different colour hand rail this does not help identify where you are or how to get to where you want to be.

There is a large laundry in the basement area of the home. All other facilities are on the ground floor including a large catering kitchen and lounge and dining areas for each of the units.

The home has a registered manager who has been in post for 15 months. 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.

At the last inspection in July 2015 four breaches of the regulations were found in the areas of; person centred care, good governance, meeting nutritional needs and the environment. The CQC was provided with an action plan stating the areas identified in breach would be addressed by April 2016. We inspected the provider before this date as we had received information of concern by way of complaints and whistle blowers. We did look at the action undertaken so far by the provider to address the concerns but are unable to take any further action until after the deadline has been passed.

At this inspection we found the home were in breach of nine of the regulations. Two of which had been identified previously and a further seven found at this inspection.

We found whilst the staff in post were motivated and committed to delivering a quality service in all but one of the units this was not borne out due to a lack of suitably qualified and experienced staff. People living in

the home and their family members told us there was not enough staff and we saw on each day of the inspection circumstances where more staff was required. This included over 20 people still in their bedrooms undressed at 11am. We spoke with a number of these people and some were ok with this situation and others were not. We asked four people if this was usual and were told yes.

People were not routinely asked for their consent before support was given and it was not always given in a timely way when it was requested. We saw people calling out for help when no staff were available. One person told us they were asking for help for up to twenty minutes and eventually the cleaner came in to see what they needed. We saw people were not always treated respectfully and their dignity was not upheld. This included people being fed food when they had said they didn't like it and doors not being closed without being entered when people were being supported with their personal care.

We saw people were often sitting in chairs that were tipped back restricting them from getting up. We were aware of safeguarding concerns which identified staff were unaware of the legalities around restrictive practice. We looked in the files of people being supported in this way and did not see any effective assessments to support this type of intervention.

Risk assessments had been completed to ensure people living in the home and staff were safe but these were not always followed. Where professional checks had identified concerns these had not routinely been followed up and not all records showed equipment was safely tested to ensure it was in working order.

The building and environment were difficult to navigate and the provider had not taken the required action to ensure it was suitable for the people living in it. The purpose of actions taken thus far to support people living with dementia had not been suitably understood to ensure they were fit for purpose. For example a pictorial menu board had been purchased with pictures of plates of food decorating the border. For this to be effective the board should only contain pictures of the meals on the menu as the others simply added as a distraction away from the purpose of simplifying the menu.

The provider had a comprehensive complaints procedure but not every complaint received at the home was managed in line with the procedure. The home had three recorded complaints in the last 12 months but the CQC were aware of five complaints received in the five months preceding the inspection. Two of which the provider was aware of without being previously informed by the CQC.

Audits had been completed monthly and a system was in place to monitor service provision. However we found the audits did not always identify the issues external professional audits identified. This included fire doors that were not up to standard and medication administration procedures that required further thought.

We found that where the provider assessed people's needs they developed care plans to meet those needs. However when we spoke with people it was clear that some specific needs had not been assessed. Reviews of people's needs were completed monthly or when people's needs changed. We saw changes at point of review were incorporated into plans of care and people's needs were mostly met. Some people or their relatives we spoke with told us they were involved with developing their care plans and staff we spoke with knew people living in the home well.

The food at the home was varied and a menu had been developed in consultation with people in the home. The chef was aware of people's dietary needs and changed people's diets to better support them when they were losing weight.

People's medicines were managed well with staff were following the home's procedures. We saw medicines were administered safely and people in the home received their medicines as prescribed.

Activity coordinators were in post at the home and we saw a number of activities taking place with the people in the home over the course of the inspection.

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

## 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 were not enough staff to meet the needs of people living in the home in a timely manner.

The provider had assessed the risks to people living in the home but these were not always followed.

We found some people's movements were restricted with the use of chairs that tipped back without appropriate assessment.

Medication was managed safely and administered in a dignified way.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were supported to receive enough nutrition and hydration.

People's consent was not formally and lawfully acquired before care was provided. The Mental Capacity Act 2005 was not fully implemented at the home.

Staff were not supported by a comprehensive induction and once in post, were not actively encouraged to further develop their skills and knowledge.

### Is the service caring?

**Requires Improvement**

Some aspects of the service were not caring.

Some people we spoke with were involved in developing their care plans. However, they were not routinely supported to make choices in their day-to-day lives.

People were not always treated with dignity and respect, we saw a number of occasions where staff behaved inappropriately

We saw people's preferences were incorporated into their plans of care including the receipt of a daily paper and influence over the menu.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Activities were available and we saw people taking part in these who told us they enjoyed them.

Care plans included information about people. However, plans were long and it was difficult to identify the planned delivery of care.

The home's complaints procedure was not fully implemented.

### Is the service well-led?

**Requires Improvement**

The service was not always well led

A system of audit was in place but it was not effective in driving improvement.

Where risks were identified, action had not been taken to rectify or mitigate those risks.

Staff did not feel supported in certain circumstances which may leave them at risk. We were given assurances this risk would be managed.

Care Quality Commission

# Preston Private

## Detailed findings

## Background to this inspection

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

This inspection took place on the 10, 11 and 12 February 2016. The first day was unannounced. The inspection team included two adult social care inspectors, a nurse specialist advisor and an expert by experience. An expert by experience is someone who has experience of, or has cared for someone who used this type of service. On this occasion the expert by experience had experience of caring for an older person.

Before our inspection, we reviewed the information we held about the home, requested information from the Local Authority and the local NHS Clinical Commissioning Group. We also reviewed any information held in the public domain.

During the inspection we spoke with 23 people who lived in the home and seven visitors. We also spoke with 18 staff including the registered manager, services manager and area manager; nurses, senior carers and care staff and the kitchen, laundry, domestic and maintenance staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed information the home held on monitoring people's specific needs, including food and fluid charts and personal care records. We also reviewed information the management team held to improve the provision of the service including accident and incident records and details of feedback received from people living in the home and their families.

We reviewed the care file information of 20 people living in the home and the personnel records for five staff.

We observed how support was provided to people living in the home, including how their medicines were

administered. We also saw how people spent their days for the length of the inspection and observed how staff responded to requests for support.

We looked around the physical environment of the home, including bedrooms, communal areas, the laundry and the kitchen. We looked to see if the environment was suitable for the people living in it, including if it was safe and maintained to a suitable standard.

Inadequate

# Is the service safe?

## Our findings

When we asked people if they felt safe we got a mixed response. Two responses were positive with one person saying, "Everyone makes me feel safe." Predominantly respondents told us at times they did and other times they didn't. One person told us, "Sometimes there is staff about and sometimes there isn't. When we get in the lounge we are often left on our own and that's when things can happen." We were shown someone with a black eye who had fallen in the lounge some time ago when there was not any staff about."

We looked at the personnel files for five staff. We saw each had completed an application and references had been received. In three of the five files we saw evidence of DBS (Disclosure and Barring Service) checks but in the other two there were only applications and no details of their receipt. We spoke with the manager about this who told us the initial ISA (Independent Safeguarding Authority) checks had been completed and the two staff did not work unsupervised. However there were not any risk assessments in the files to clarify this. We also noted one reference received was not positive and employment had not been offered initially. This was overturned and the person was employed but again there was no risk assessment to clarify the rationale for this and how this would be managed. In two of the files we saw one set of interview notes and the others did not have any. Only one of the five people had evidence of a completed induction.

We asked the manager how they determined the staff the home needed to support the people living in the home. We were told a dependency tool had recently been completed which going forward would collate the monthly dependency assessments completed on people living in the home every month. We found, when we looked at people's care plans the individual assessments had not always picked up on some of the complexities of people's needs nor did it include hours for staff training, holiday or an estimate of staff sickness. We were assured the new tool would incorporate these hours into the collated dependency tool. On each day of the inspection we saw it took the nurses up to five hours to administer the medicines people required. This meant this nurse was not available to support people whilst administering the medicines yet they were included in the assessment of required staff to meet people's needs. The dependency assessment did not allow for the time taken to administer medicines or people's changing needs as staff numbers had not increased for some time.

We saw people waiting for up to 20 minutes to receive staff support and approximately half of the people we spoke with told us they had to wait to get the support they needed to get up in the morning. A large number of people were still in their rooms requiring support at 11am.

The CQC (Care Quality Commission) had received a number of concerns about the home being short staffed. When we spoke to the manager we were told this could sometimes happen when staff called in sick at short notice. We asked one of the nurses who worked the night shifts if they could cover shifts with agency staff if required and were told if the shift was not covered by the day staff it was usually left unfilled. The provider needs to establish a more reliable method for covering shifts at short notice and ensure night staff are aware they have the authority to cover shifts where they can. We were told the home was always recruiting staff and saw from meeting minutes this was the case. However short term sickness was still an issue and left shifts understaffed.

A lack of suitably trained staff to meet the needs of people living in the home is a breach of regulation 18 (1) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We saw safeguarding procedures were available for staff and visitors in the home. A poster was clearly displayed in the reception area and in the staff room. We saw from training records that 73% of staff had received safeguarding training in the last three years. Training would shortly need to be renewed for over 10% of those.

We looked at how the home protected people from forms of abuse including ensuring people were not restrained unlawfully. We saw over 10 people sitting in chairs that tipped backwards stopping them from being able to get out of them. Chairs of this type can be used to support people when they are unable to safely mobilise. We looked in the care files for four of these people and did not see any form of risk assessment to ascertain why people needed the support of the chairs. We asked staff how the use of the chairs was agreed and were told some people were more comfortable in them but there were no assessments to support this.

When people's movement is restricted in this way without appropriate assessment or consent, it is unlawful and is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a comprehensive accident policy linking accidents and incidents with other procedures including safeguarding and any required notifications to the CQC. A monthly log was completed which identified themes and trends. However the log identified over a third of entries as 'other'. The accident record had a good selection of options to record the type of accident and the manager assured us they would transfer this list to the log so all accidents could be categorised. The log provided guidance on what to do with specific accidents including referrals to the falls team if required.

We saw some risks associated with how medicines were administered had not been assessed including one person who had approximately eight medicines crushed and administered through a PEG (Percutaneous Endoscopic Gastrostomy) tube. The method for doing this had not been reviewed for some time and the home had not sought the advice of the pharmacist to ensure how they were administering the medicines was safe. Following the inspection the CQC inspector was in contact with a Medicine Optimisation Pharmacist (MOP) who was to review the medicines in the home.

We saw risk assessments that were written to keep the environment safe. A health and safety risk assessment stated tools should not be left unattended but when we first arrived on the third day of the inspection, we saw the maintenance staff's trolley left unattended with the maintenance staff nowhere close by, this was also the case on the second day of the inspection. We requested a staff member find the maintenance staff and we waited with the trolley until they returned. The trolley had hammers, screwdrivers and other tools which were easily accessible. We also saw a risk assessment for the management of potential aggression. The assessment stated all call bells would be tested monthly. We saw approximately 50% of call bells had not been tested for over 12 months.

We saw people had Personal Emergency Evacuation Plans (PEEPs) in their files. However these were not in with the contingency plan. We also saw the contingency plan which should be used in the event the service was interrupted or stopped, did not include key details including contacts for social workers, family members and other key stakeholders. The plan did not include details of how to manage the service if it was interrupted for longer than 12 hours. This meant the service was at risk in the event of a major incident including fire or flood.

The building had a small fire in March 2015. The records showed the fire was dealt with appropriately and everyone was kept safe. A further risk assessment had been completed in July 2015 where a number of actions were required. This included work on 30 fire doors. We reviewed the information available for the monthly fire tests and found they were not clear on what had been tested. The absent information included details of where the alarm had been activated, what route was tested and what action needed to be completed including any required training. The record for the test completed in December 2015 showed only 8 out 11 staff attended but did not identify any action as a consequence.

We saw certificates of professional testing of equipment and saw most were within the expected period. However the last electrical installations certificate dated 23/1/2012 was unsatisfactory and the test was failed. The action had not clearly been addressed and a re-test certificate showing the test was passed was not available.

Where risk assessments are not in place or are in place but not followed and the required testing of equipment either professionally or by the provider is not undertaken this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Over the three days of the inspection we observed part of three medication rounds. We reviewed the medication policies and procedures and looked at how medicines were stored and managed. We saw nurses administering medication knew about people's needs when giving their medicines. This included how they liked to take them and what time. We saw people did not refuse their medication during our observations but saw from records that when this happened it was recorded appropriately.

We observed how nurses asked if people required their 'as required medicines' and saw they approached this in different ways when people had difficulty in understanding what was asked of them. We saw nurses followed procedures when administering eye drops and other topical products and specific instructions were followed for early administration of medicines and those that required intermittent testing of bloods or blood pressure.

We looked at the MARs (Medicine Administration Records) on the two nursing units and the residential unit and saw they included a photograph of the person and any known allergies; this reduced the risk of people receiving the wrong medicine. We also saw a list of signatures for all staff administering medicines.

We were told how the home managed medicines that were required short term or mid medication cycle including antibiotics. We reviewed records for receiving and disposing of drugs and saw the nurses understood and followed procedures. We also saw medicine fridges were locked in the medication rooms and temperatures were checked daily. Records we saw were within the acceptable range.

We looked at how the home stored and managed controlled drugs and they were stored in line with regulations. We consolidated two medicines with the available records and they were as recorded. We saw boxes and cartons of medicines were dated when opened and were all in date on the day of the inspection.

Each unit in the home had a dedicated sluice used for the disposal of clinical waste. We noted there were no clinical waste bins in any of the bathrooms, in which personal care and clinical waste would first be handled. We saw staff walking through long corridors with bags of clinical waste. The ideal situation would be to have waste reciprocals at point of need. This would reduce the risk of cross contamination and infection as well as be more dignified for people living in the home.

However it had to be noted the home had a recent outbreak of Gastroenteritis which was contained to one

unit and records we reviewed showed the outbreak was managed effectively and risks were mitigated as required.

On the second day of the inspection there was a clear lack of available PPE (Personal Protective Equipment). By later that afternoon it was evident staff had been asked to ensure they used the appropriate PPE and it had been made available to them.

We reviewed how the home managed clinical soiled clothing and were told of a procedure that would ensure items were laundered appropriately and any risks associated with clinical waste would be reduced. The laundry staff acted on recommendations to improve procedures within a couple of hours including ordering a red coloured laundry bin to hold items that may pose a risk prior to washing. This would help ensure the same bin was not used to hold regular laundry.

We saw there were records used to monitor that the home had been cleaned and that rotational cleaning tasks were completed including cleaning microwaves and equipment in the satellite kitchens.

Most of the furniture in the home was of a good standard and it was clean and could be wiped clean, each bed we looked at had a wipe-able mattress cover.

We recommend the provider reviews how they manage clinical waste and ensures there are appropriate facilities at delivery of care.

We recommend the provider reviews the information obtained at point of recruitment and is satisfied evidence is available to ensure the person is suitable for the role.

Requires Improvement

# Is the service effective?

## Our findings

When we asked people living in the home if their needs were met, again we got a mixed response. Some people told us they did not need lots of support and staff were available when they did but others told us they had requested additional support and it had not been provided. This included support with people's vision, nails and skin. One person told us, "I've told staff about my legs and they have told me they will get it sorted, but they haven't. They shouldn't say they are going to do things and then not do them."

We observed how staff provided specific support including using the hoist, moving people in bed and supporting people with their meals. We found a mixed picture with some staff attempting to provide support that would have been better provided with two staff, for example supporting someone to the sitting position in bed. We also saw others supporting people with their food that required more training including someone who was blind in one eye having their meal put in front of them in a way that made it difficult for them to eat their meal. Staff did not appear to understand how this person could be better supported.

We looked at training records available for the staff team. We found nearly 80% of staff had attended the required mandatory courses for the provider group. We spoke with four clinical staff about the clinical supervision they received, the competency testing and the additional clinical training. We spoke to one nurse who had received training in the last year on the specialised equipment used.

In four of the five personnel files we looked at we did not see any evidence of the support staff received through the company probation period. In one file we saw the probationary period had been extended by three months. Only one of the files had any information to support the staff member had received an induction to their role.

We were told staff had regular team meetings and those we spoke to that had attended them said they were informative. From the information we saw and what we observed, it appeared staff were competent in their role. However we found that people with more complex needs were not always provided with the support they required in a timely way. We concluded the home required staff with more clinical knowledge to meet everyone's needs.

We looked at the information held by the home to show people had given their consent to various aspects of their care and treatment. We looked in six files and did not see any consent signed by the people living in the home. Each consent form we saw included details of what staff should do in the event people could not give the consent themselves. This included the completion of a best interest meeting to ensure the care or support provided was in the person's best interest. There was no evidence to show this had happened in any of the files we looked at.

The provider told us they had introduced new consent forms in September 2015 but these had not been implemented in the six files we looked in or in a further four we checked to ascertain if the form was routinely used on different units. All forms we saw were either not signed or signed by a family member of the person living in the home. We discussed the authority of the family with the manager and whilst they

told us they understood the family had no legal authority without the appropriate Power of Attorney in place, records of consent we saw did not support this and steps needed to be taken to ensure consent was gained lawfully for people living in the home.

We observed how consent was gained from people when staff were supporting them and routinely saw staff providing instruction as to how people were to be supported rather than asking for consent before providing it. For example "I'm moving you into the dining room for lunch now." Rather than. "Would you like to have your lunch in the dining room?"

When formal consent is not gained for interventions and people living in the home are not asked for consent before intervention, this is a breach of Regulation 11 of the Health and Social Care Act HSCA 2008 (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.

The manager told us they had applied for DoLS for most people in the home. In the files we looked in we saw an initial capacity assessment which determined blanket capacity or not. We did not see any clear decision specific assessments. Best interest decisions were also generic and included statements, 'To ensure all aspects of (person's name) care to be met.' We saw some steps had been taken within specific care plans to include people's capacity in the final decision of care and support required but some of this was lost in the detail. For example, one person had recently broken their arm and was consistently picking and breaking the cast required for the break to heal. Staff had covered the cast in sellotape to continue to allow the person to pick if they wanted to but to help the cast integrity remain so the break could heal. This was potentially a good best interest decision but it was not recorded effectively within the person's care file information.

At the last inspection in July 2015 we found the home in breach of the regulation about ensuring people received enough nutrition and hydration. At this inspection we saw the action plan developed by the provider to address the concerns had mostly been met.

The home had assessed the risks of malnutrition to people who lived in the home and developed plans to meet people's needs. People were weighed routinely and if significant weight was lost, GPs would be contacted and referrals made to the supporting dietician. The chef prepared food and drinks people needed with higher calorific content when people were seen to lose weight. People had appropriate supplementary records to provide extra monitoring of what they ate and drank if there were assessed concerns. Some of these records were poorly completely and did not allow for the identification of further support. For example, it was not clear what people would eat more of or less of, so the chef could prepare the foods that were being readily eaten.

At the last inspection we identified the home did not take appropriate steps to meet people's individual preferences and did not take feedback on the meals provided. We saw at this inspection steps had been taken for the chef to collate people's preferences. A new menu had been developed and the menu was discussed at every resident meeting. We saw from minutes the staff made amendments when they could to meet people's needs. We also saw the chef received predominantly positive feedback on the meals they served.

Members of the inspection team ate their lunch in different units within the home. On one of the days of the inspection we suspected the vegetables were frozen and noted from one resident meeting minutes that people had raised a dislike of the frozen vegetables. People were assured the vegetables were fresh. We asked the chef about the vegetables who told us they are boiled for much longer for people who required a softened diet. But this did not account for everyone's vegetables being boiled for a longer length of time.

We saw people were offered a choice of meal and were told by people living in the home they could have something else if they didn't like any of the options.

We observed people eating their food and saw many would have benefited from additional support. Adaptive cutlery would have been of benefit to a number of the people we observed.

We saw evidence to support that the home referred people to specialist teams as required including the dietician, district nurse and tissue viability team. The home monitored people's needs and where risks increased, made appropriate referrals.

We also saw records which showed us people had their vision and hearing tested in line with their needs and a chiropodist visited when requested. One person told us they would have liked to see the chiropodist more regularly.

At the last inspection in July 2015 the home was found to be lacking in equipment and activity to support people living with dementia. The action plan completion date had six weeks to go at the time of this inspection and we saw from meeting minutes the home considered some of the required actions had been completed including dementia signage. We found dementia signage was still limited and did not provide an environment where people living with dementia were best supported. The action plan stated memory boxes would be in place by the end of January 2015 to better support people in identifying their own bedroom and personal space. There was not one memory box in place at the time of this inspection. We would check again following completion of the action plan from the previous inspection and this inspection to ensure the work had been completed.

We spoke with the dementia coach for the provider who was developing a toolkit of training and activity materials to support people living with dementia. The toolkit and training was in the final stages of development and had yet to be finalised, delivered and implemented.

The building had predominantly white walls and there was no sign of any meaningful activity taking place. We were told that some rummage boxes had been developed for the dementia unit but we did not see any. When we asked staff on that unit where they were we were told they had disappeared. The home had not taken adequate steps to meet the needs of people living with dementia. This is a breach of Regulation 15 (1)(c) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We recommend the provider reviews the MCA 2005 toolkit and improves how assessments of capacity for specific decisions and outcomes as part of best interest decisions are recorded.

Requires Improvement

# Is the service caring?

## Our findings

We spoke with people who lived in the home about how the staff treated them. Mostly people told us they were treated well. We received comments like, "It's nice and relaxed here most of the time and most of the staff are lovely." And, "The staff are very kind." Three people told us, "One of the night staff can be rude." When we asked why they thought that, two people said. "There are not enough staff at night and they have too much to do." We spoke with the manager about this, who was aware of the concerns.

We looked at people's files which all held information about the person's past life. They also contained information about people's interests and what they liked to do. We saw one person liked to read the paper daily and we saw they received a paper. We saw newspapers were delivered to a number of people in the home on each day of the inspection.

Some people liked to attend church and we were told someone visited from a local church monthly and people could attend communion if they chose to.

During our observations we saw a number of people shouting out for staff on each day of our inspection. We heard comments like, "Stop ignoring me." And, "Will you please come to me quicker." When we spoke with these people they all said there were not enough staff. We also saw people left unattended for up to 20 minutes in the main lounges on the units with the potential for people to be involved in incidents or accidents.

We asked six people who lived in the home if when they have any questions, they are answered and they understand what is going on. They all told us no. Two relatives we spoke with told us the staff kept them informed, one told us they were actively involved with their family member's care plans.

We specifically observed people sitting in one of the lounges on a nursing unit for twenty minutes. We saw people were all in chairs of varying descriptions facing towards a small television. Over 30% of them could not see over the heads of the people in the row before them. People were mostly withdrawn and there was one member of staff in the room administering medication. Three staff arrived in the room shortly before we left and started talking to people in the room.

We saw staff throughout the course of the inspection entering rooms without knocking or without waiting for a reply after knocking. We observed one meal time routine where one person was being supported with their meal. We saw the staff member did not engage in conversation with the person they were supporting and rather than waiting for the person to finish one mouthful was holding the next to their lips. We saw staff telling people of course they liked the food on offer when they said they did not and consistently saw people being supported from one place to another at the convenience of the staff without any discussion with the person being supported. For example, people told 'its time for lunch I'm taking you to the dining room'.

We found staff had not received any recent training in dignity and respect but after the inspection received information that a number of staff had attended a day's training the week after the inspection.

On one unit we saw a member of staff come in and ask for the clippers. They took a pair of nail clippers out of a drawer and were about to cut one person nails with what could only be described as a communal pair of clippers. We asked the nurse on duty what the staff member was doing and they went to collect the clippers and threw them in the bin.

We asked people how often they had  baths and if they could choose when they had a bath. Everyone we spoke with told us they were given  a bath when staff said they could have one. Two people told us they would like more baths but they couldn't have them because there wasn't enough staff.

When people are not given choices or options about their daily lives, staff do not show regard for their dignity and actions are not respectful, this is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors we spoke with said they could visit when they wanted and if they requested a meal could eat with their family members.

Requires Improvement

# Is the service responsive?

## Our findings

People we spoke with who lived in the home told us if they don't want to do the activities that were on, all they got to do was watch television. Two people thought they watched too much television but most were happy with it. We asked people it they were asked about what they wanted to do or what they thought about what activities were on offer. Everyone we spoke with told us they were not asked for their opinion routinely but could pass comment on the food. One person told us, "You are the first one to ask me what I think."

We asked people when they could get a cup of tea and again all those that responded said when they were given one. However when we asked what staff could do better most were complimentary and said they were doing their best and put it down to the fact that there were not enough of them [staff] to do the things they wanted to.

We looked at the home's complaints procedure and saw how complaints should be managed. The home had three complaints in the complaints folder for the last 12 months. Each complaint had a check list attached to it which included details of how the complaint was logged, responded to, investigated, actioned and closed. The last complaint in the file was dated August 2015 and the checklist had not been used. The action taken had not been confirmed and the outcome had not been recorded.

The Care Quality Commission (CQC) had received five complaints about the provider since October 2015 and none of them were in the complaints file. The registered manager showed us a file they kept with the information of concerns raised with them by CQC. We had informed the provider of three of the complaints we had received and the information of the managers investigation was held in this file. However one complaint CQC had been copied into had been sent directly to the provider and the provider told us they were aware of the fifth, but neither of these were investigated in line with the provider's complaints procedure. There were a number of other complaints the provider told us they had received which were not recorded.

When providers do not keep a record of all complaints they receive and keep details of how they have been managed there is a possibility issues and circumstances which led to complaints could reoccur. Providers have a responsibility to where ever possible, mitigate risks leading to complaints they receive. Providers and staff cannot improve ways of working as a consequence of complaints if these records are not kept. This is breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We looked at the care files for 20 people who lived in the home. We looked at files from all units receiving different types of care or nursing support. We found the files were disorganised and information in them was difficult to find. We found a lot of the information was repetitive and some of it was very old and no longer relevant.

Information in people's files was reviewed monthly and where required we saw care plans were updated. There was supplementary information in people's rooms where additional support was required. We saw

this information prompted assessment and referral where required,  for example to the tissue viability nurse when staff were supporting someone with pressure areas. However we also saw some of this information was not routinely completed. For example one person's supplementary charts had not been completed for the 24 hours prior to the inspection. This person required a number of staff to support them with personal care and repositioning in bed but these had not been recorded. We spoke with the person who told us they had been supported in the last 24 hours.

We saw people had one page profiles in their rooms identifying their key support needs including diet, mobility and continence needs. These did not always correspond to the support the person told us they received. For example one person's profile said they needed four people to move them but we were told routinely it was only two or maybe three. One other person's profile said they had a normal diet but their file information stated they shouldn't eat spicy food. The reason for this was unclear in the file information and staff were also unsure.

People's rooms had notices on to say whether the person in the room liked the door open or shut. We saw the door was positioned how the notice directed. We spoke with people and they assured us the notice was good direction of how they liked their door to be left. This showed us staff responded to this request as appropriate.

We saw in some of the files there was information on people's past lives before coming to the home. This information had been added to care plans and some care plans had been merged since the last inspection. What we found was that this made plans of care long and it was difficult to determine what the actual planned care was. By merging skin integrity and mobility into one care plan meant there was a lot of information about continence care, moving and handling and pressure care in one plan. Whilst we acknowledge all are aspects of meeting an identified need by having all the information together in this way, it was not explicit how each risk or need was to be addressed. The nurse specialist advisor discussed this in detail with one of the nurses on the day of the inspection who was keen to improve how plans of care were written.

We saw a number of compliments and cards of thanks had been received by the home. We also spoke with family members who were very complimentary of the staff involved with delivering direct care to their relatives.

Requires Improvement

# Is the service well-led?

## Our findings

The home had a registered manager in post who worked five days a week for the provider. The manager was supported by a deputy and a services manager who was responsible for the housekeeping and catering at the home. Each unit had a unit lead who took responsibility for the staff and ensuring people received the support they needed.

Staff we spoke with told us they felt supported by the unit leads and by their peers but most said they were very busy and could do with more staff. We were unable to view the minutes of any team meetings as they were unavailable but staff told us there had been one in the last three months. Staff we spoke with said they received supervision but this was not very regular and annual appraisals were currently being arranged. Clinical staff told us they wanted more support and training around clinical support including tissue viability and keeping clinical notes. Clinical staff had not received clinical supervision for some time.

We spoke with eleven staff who delivered front line care and support to people living in the home. We were told of specific incidents that had led to staff feeling deflated, potentially intimidated and indeed at times physically upset. We spoke with the manager about how staff were supported at these times. The manager acknowledged at times situations could be difficult and staff may feel unreasonably implicated in incidents and situations, which were sometimes beyond their control. We advised the manager to complete a business risk assessment of these situations and share it with staff so staff could feel they were protected when these situations arose. We were assured the manager would undertake this piece of work to ensure staff and people living in the home were protected.

When staff are not supported to competently and confidently complete their duties and clinical staff are not enabled to continue with their professional development it is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with knew who the manager was and felt they knew the staff that cared for them. We were told by people living in the home and their relatives that the manager was not always on site. We saw meeting minutes which told residents and relatives the only time the manager was off site was to complete assessments which was one or two days a week. The manager told us that they had been supporting another manager's induction at a different site for up to two days a week. This meant that potentially the manager was off site for up to four days each week which would make it difficult for them to oversee the day to day management of the building. We were assured this arrangement was soon to come to an end and the manager would be on site more.

At the last inspection in July 2015 it was found the audits and monitoring were not effective at identifying concerns and issues as identified within the inspection. The CQC were given an action plan which told us the required improvements would be in place by April 2016. The home undertook a number of monthly and quarterly audits on the building and environment. We looked at a number of these audits to determine how effective they were. One audit completed in March 2015 on the water system identified some aspects of the system could not be audited due to restricted access. This and other actions had been identified at the audit

12 months previously and there was no record of any action being taken. We asked the maintenance staff about this and were told the access was in the roof space but it was not safe. A risk assessment had not been completed to mitigate either the identified risk or the system not being audited.

We looked at the home's records for the temperature of the water. Records were kept monthly internally and professional testing was undertaken periodically. We saw internal and external records for March 2015 and the records differed significantly. There was no action identified to address the issues identified on the external testing record.

We saw other monitoring records for the water outlets, call bells, profile beds and infection control and saw the audits were not effective. For example the water outlet and call bell audits only tested a restricted number of points. The points tested did not rotate meaning some points had not been tested for over 12 months. The profile bed audits and infection control audits stated equipment was in place when it was not, including bumpers on all bed rails and the safe storage of chemical cleaning equipment. There was not a monthly monitoring record which evidenced these things were physically checked. We saw the infection control audit considered a monthly housekeeping audit but a recent housekeeping audit was not available on the day of the inspection. We were assured after the inspection they had been completed but were held on the units and had not been provided for us.

We saw other audits for the kitchen, environment and medication. We saw most audits did not identify any concerns or action required. From the evidence we reviewed we found the audits were not being used effectively to improve provision. At the last inspection in July 2015 this was identified as an issue and more work was needed to ensure this regulation could be met.

The area manager did a monthly audit. We reviewed the ones available on site and saw the last one available had been completed in October 2015. The manager could not find any more recent ones but we were sent the audits for December, January and February following the inspection. We found the audits were completed by different people and there was not a check of the actions from the previous completed audit. This made it difficult for the auditor to have assurances the actions from previous audits were being completed. We found actions from the previous inspection had not started to be addressed and whilst we were shown a comprehensive audit tool the provider had developed, this was yet to be embedded. A system of audit and monitoring needs to be embedded before it can be effective. We found at this inspection the home was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an electronic data system that could pull reports for quality assurance. These included overviews of people in the home that had lost weight, those with pressure sores etc. the manager could share the information with the unit leads and department heads to ensure those people requiring more support received it.

The home had regular resident and relative meetings and people we spoke with them took part and welcomed the opportunity to feedback on the service they received. We saw from minutes that the home supported people's requests wherever possible. We saw the minutes of these meetings were made available to people and were kept in the back of the supplementary information folders in people's rooms. This meant that people who could not attend the meeting had the opportunity to review the information.

A resident of the day system and been re-launched using a more comprehensive format. We did not see any of these completed but people we spoke with were aware of the process and one told us they enjoyed it when it had been their day. The new format encompassed giving the resident of the day their choices of

activity and different departmental staff visiting the person to ensure their specific and individual needs were being met.

There were various notice boards around the home that held information for people in the home and their relatives. This included information on support groups including advocacy services. There was also information on how to complain and details of the safeguarding team if people or staff were concerned about how people were supported.

There had not been a formal request for feedback from staff or residents for some time but we were assured this was due to take place and were shown letters and a copy of the questionnaire that was to be sent out.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Regulation 10 (1) (2) (a) (b)<br>People were not routinely involved in their own care and care and support was not always delivered respectfully with consideration of peoples' dignity. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Regulation 11<br>Care and treatment was provided without the required and lawful consent. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12 (1) (2) (b) (d) (i)<br>There were not have effective systems to protect people from assessed risk and not all risks had been assessed. Where risks were assessed they were not managed appropriately and identified action to reduce risks was not undertaken.<br>The premises professional testing of equipment had not been complied with and action was not evident to ensure compliance was reached.<br>Appropriate steps had not been taken to protect people in the event of a major incident. |

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Regulation 13 (1) (4) (b) (c) (7) (b)<br>People were not safe because staff did not understand what procedures were required before restrictive practice could be lawfully undertaken. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>Regulation 15 (1) (c)<br>The building and environment did not meet the needs of the people who lived in the home. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>Regulation 16 (1) (2)<br>Procedures for managing, investigating, recording and responding to complaints were not followed. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 (1) (2) (a) (b) (f)<br>The service did not have effective systems to monitor and audit the service. Risk assessments were not always completed and key documentation used to protect people from unnecessary risks was not monitored and quality assured. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Regulation 18 (1) (2) (a) (b) (c)<br>There were not enough suitably qualified and trained staff to meet the needs of people living |

| | |
|---|---|
| Treatment of disease, disorder or injury | in the home.<br>Staff did not receive appropriate support to enable them to carry out the duties they are employed to perform.<br>Staff were not supported to obtain further qualifications appropriate to the work they perform or enabled to evidence continued professional development as the requirement for their role. |