Bupa Care Homes (ANS) Limited

Carnarvon Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 17 August 2016 and was unannounced.

Carnarvon Care Home is a care home that provides nursing and personal care to older people, people with a physical disability and younger adults. The home can accommodate up to 57 people. The home is owned by Bupa Care Homes (ANS) Limited. On the day of our inspection there were 34 people living at the service.

There was a registered manager. 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.

We carried out this focused inspection in response to concerns raised by people's relatives and the local safeguarding authority. We found major concerns regarding the overall clinical leadership of the service, the lack of action taken by the provider to safeguard people in the management of their medicines, monitoring to ensure people were sufficiently hydrated, pressure ulcer prevention and the lack of monitoring to ensure their complex nursing needs were being met. The provider was not meeting the requirements of the law as they did not monitor effectively the health and nursing care needs of people and identify people at risk of receiving care or treatment that was inappropriate or unsafe.

There was a lack of monitoring to ensure people received adequate support to maintain adequate nutrition and hydration to prevent ill health. People were not effectively monitored for pain or receiving adequate pain relief medicines as prescribed.

We found there to be insufficient staff at all times to support the high number of people who required two staff to assist them with their personal care and when mobilizing using a hoist. This was evident from our observations and discussions with staff and relatives.

People were not receiving appropriate monitoring which placed them at increased, serious risk of harm. For example, there was a lack of monitoring to ensure people received adequate support to maintain adequate nutrition and hydration to prevent ill health. People were not effectively assessed and monitored for pain.

Prior to our inspection we received information of concern from the local authority that the service was providing inadequate monitoring of people at risk of acquiring pressure ulcers. We found that risks associated with the use of pressure relieving equipment and the use of bedrails had not always been appropriately assessed and guidance was not provided for staff in the correct use of equipment. There was no system in place for the safety monitoring of pressure relieving equipment. Air mattresses were found to be set at incorrect air pressure settings. This increased people's risk of acquiring a pressure ulcer.

Infection control monitoring within the service was in need of improvement. Hoist slings were not always

provided for individuals and used for several people presenting a risk of cross infection. Staff did not always follow safe procedures to protect people from the risk of cross infection.

People who could not bear their weight were put at risk due to ineffective assessment of risk and a lack of appropriately assessed equipment provided. This meant action had not been taken to review their care ad ensure their safety when supported by staff to mobilise with lifting equipment such as hoists and slings.

We observed interactions with people from some staff which identified a culture of task focused care which lacked attention to providing quality care which prioritised meeting the individual needs of people.

We found at this inspection the quality and safety monitoring of the service was ineffective at identifying where the quality and the safety of the service was being compromised. We found the monitoring and auditing of people's medicines inadequate and in need of improvement. There was insufficient clinical oversight which monitored the quality of the nursing support provided to people with complex nursing needs, ineffective assessment of risk and action taken to mitigate the risks to people of receiving unsafe care and treatment.

Immediately following this focused inspection we formally notified the provider of our concerns and placed conditions on their registration instructed them to take urgent action to mitigate the risks to people's health, welfare and safety and a condition to stop them admitting any further people to their service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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.

We found major concerns in relation to the management of people's medicines and the overall clinical governance to ensure people's complex health care needs were being met.

There was insufficient staff, effectively deployed and available at all times to meet people's care and treatment needs.

Is the service effective?

Inadequate

The service was not effective.

Consent to care and treatment was not always sought in line with legislation and guidance.

Care and treatment for people at risk had not been effectively assessed or planned for. This placed people at risk of not having their health, welfare and safety needs met. Nor had they been asked about their preferences for their end of life care.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff treated people in a kind and compassionate manner this was not always demonstrated by others. People's care was not always planned and provided in a personalised, respectful manner.

People could not be assured their confidentiality of information would be protected.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not reviewed regularly to reflect people's current care needs and lacked sufficient information and guidance to guide staff in mitigating risks to people's health, welfare and safety.

People did not always receive the care and treatment they needed at the times that they needed or wanted it.

Is the service well-led?

Inadequate

The service was not well led.

The quality and safety monitoring of the service was ineffective at identifying where the quality and the safety of the service was being compromised.

There was insufficient clinical oversight or monitoring which affected the quality of the nursing support provided to people with complex nursing needs. The lack of affective assessments of risk and the failure to take action to mitigate them put people's health and welfare at risk.

Carnarvon Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 17 August 2016 and was unannounced on both days.

This inspection was carried out by three inspectors, a pharmacy inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of providing care and support for an older person.

Prior to our inspection we had received concerning information about the service provided; these had been reported to and investigated by the local safeguarding authority. We spoke with the local safeguarding authority and reviewed information sent to us from stakeholders. The local authority kept us updated with the support that they were providing to the service to assist them to improve the care and support provided to people. During our inspection we looked to see what action had been taken as a result of these concerns.

We looked at other information we held about the service including statutory notifications. This is information providers are required to send us by law to inform us of significant events.

We spoke with nine people who were able to verbally express their views about the quality of the service they received and six people's relatives. We observed the care and support provided to people and the interactions between staff and people throughout our inspection.

We looked at records in relation to nine people's care. We spoke with the deputy manager, the regional director, three nurses, seven care staff, the chef, two domestic staff and two activities coordinators.

We looked at records relating to the management of medicines, staff recruitment, staff training and systems for monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

We found major concerns in relation to the management of people's medicines and the overall clinical governance of the service in meeting the nursing needs of people with complex health care conditions.

Prior to our inspection we received information of concern from the local authority that the service was providing inadequate care planning, management of people's medicines, the monitoring of people at risk of acquiring pressure ulcers and unsafe moving and handling practices carried out by staff.

We looked at records in relation to the systems in place for managing medicines; spoke to nursing staff involved in the administration of medicines and examined nine people's medicines administration record (MAR) charts.

Most of the liquid medicines had the date of opening on them but we found one medicine that had expired 10 days earlier and was still being used and another medicine that only lasts eight weeks had no date of opening on it. Medicines requiring cold storage were kept within monitored refrigerators in the treatment rooms, however on three separate occasions one of the refrigerators had been recorded as being outside of the recommended temperature range and there was no evidence of any action having been taken to investigate. Insulin pens were not always marked with the date they had been removed from the refrigerator, so staff would be unaware of when they expired and an inhaler which only last 6 weeks after opening hadn't been appropriately marked.

Where people were prescribed topical creams and lotions we found gaps in MAR records to evidence when staff had administered these medicines. This meant we could not determine if people had received theses medicines as prescribed. We found a large tub of emulsifying ointment, which had a name written on it in marker pen which had smudged and not clearly legible. There was no prescription label or date recorded of opening. Tubs of cream are accessed by people's fingers and should be discarded after one month to prevent the risk of bacterial growth.

We noted people that not everyone receiving their medicines via a Percutaneous Enteral feeding tube inserted into their stomach had the capacity to understand that medicines as well as nutritional supplements were being administered down the tube. Covert administration of medicines may take place when a person lacks the capacity to understand why they need to take the medicine and only if protocols have been followed prior to any decision made to administer medicines covertly. This would ensure that consideration has been given to ensure a person's human rights have been upheld in accordance with the Mental Capacity Act 2005. We noted that no best interest's decisions had been made following assessment by those qualified to do so on behalf of people receiving their medicines covertly. These assessments would include the relevant health professionals and the person's relatives. Where medicines are crushed and administered via a tube, there was not always clear instructions on the MAR chart on how to do this and in one case a medicine was being administered at an inappropriate time as it needed to be administered just before a Peg feed and was administered in the morning and the feed was not started until 6pm. Procedures in place to protect people being given their medicines in a covert manner or when crushed and

administered via a tube had not involved consultation with a pharmacist to address these issues.

One person approaching the end of life, anticipatory medicines had been prescribed and received into the home but had not been written on the MAR chart therefore staff would have been unable to administer them in a timely manner if the person had required them.

Staff knew how to report a medicine incident but we only saw two medicine incidents that were reported in July 2016, there were no records available for any other incidents that had occurred between January 2016 and June 2016 that had been identified by the local Essex County Council quality and improvement team following their visit in July 2016.

Nursing staff had not received any recent checks to confirm their competency to safely administer people's medicines.

There was a lack of clinical oversight and review of daily health and welfare monitoring records.

We noted that fluid monitoring charts had not been fully completed to calculate within a 24 hour period the amount of fluid a person at risk of insufficient fluid intake had consumed. We noted food and fluid monitoring forms required that a nurse or clinical lead monitor daily to ensure people had received adequate intake and were required to take and record actions taken in response where people were at risk of inadequate intake. However, of all the records we reviewed not one had been signed as checked by a nurse or clinical lead. Where it was evident in these monitoring records that people had received inadequate amounts of food and fluid, there was no evidence this had not been followed up and no evidence of action taken in response to safeguard people from the risk of malnutrition.

There was a lack of clinical oversight and a lack of action taken to mitigate the risks to people's from inadequate hydration and to sustain life and health. People's weights had been regularly monitored and management audit tools checked that these had been completed. Two people who had been consistently losing weight action had been taken to refer them to a dietician for specialist advice. Recommendations made were for these people to receive regular snacks, fortified food and pro cal nutritional supplements. We noted from a review of their food and fluid intake records that no snacks had been offered from the records available for the last five days, there was limited recording of nutritional supplements having been provided and there were large gaps where staff did not evidence that food had been provided at all meal times. Where their daily total of fluid intake was clearly insufficient to maintain good health, there was no evidence that this had been responded to and action taken to protect these people from the risks associated with inadequate food and fluid intake. Therefore the effectiveness of these charts was in question at identifying and providing evidence that action had been taken to protect people from the health risks associated with insufficient fluid intake and at risk of dehydration.

We found that risks associated with the use of pressure relieving equipment and the use of bedrails had not always been appropriately assessed and guidance was not provided for staff in the correct use of equipment. There was no system in place for the safety monitoring of pressure relieving equipment. Air mattresses were found to be set at incorrect air pressure settings. One person with a weight of 44.1kg had their pressure setting between 5-6, appropriate for a person weighing 108kg. Their care plan recorded the mattress pressure setting should be set at 6-7 which would be a setting for a person far in excess of 108kg. Another person was found with their air mattress deflated lying flat against the bed base. This had not been noticed by staff and was identified by one of the inspection team. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support.

The impact for people where pressure mattresses were set incorrectly placed them at risk of further pressure damage. We asked a nurse what systems they had in place for the regular audit of pressure relieving equipment. They told us they were not aware of any regular audit in place to mitigate the risks to people.

We were informed by the deputy manager that people had their allocated sling when they needed to use the hoist and a current risk assessment in their care plan guiding staff how to use equipment safely. Care staff told us that people's slings could be found either in their room or a nearby bathroom. We found a sling belonging to one person in a bathroom on the ground floor when this person's room was located on the top floor. The sling had a date of issue as March 2012. We reviewed their risk assessment and looked in their room to see what sling they were using. The risk assessment was dated 14 August 2016 and so this had just been reviewed. The risk assessment was specific in that it stated the person required a specialist sling for amputees and they required the use of a full body hoist. However, we found in the person's room a sling in use that was not suitable for their use. This meant this person was at risk as staff were not following the risk assessment and had been provided with inappropriate equipment to ensure the safety of the person.

We wanted to establish and confirm that slings were regularly checked as per national guidance to check they were in good order and safe to use, without tears or frays and replaced where faults may be found. We spoke with the maintenance person who confirmed there was no current system for checking the integrity of slings in use on a daily basis. This put people at risk of injury if slings are not routinely checked to ensure their safe use.

We spoke with one person who required support from staff with using the hoist to mobilise from their bed to a chair and for personal care in the bathroom. They told us, "Being hoisted is uncomfortable, but it has to be done." They explained that because of a condition affecting their heel they were unable to weight bear. We looked at their moving and handling risk assessment which confirmed this person was unable to weight bear. However, the guidance provided for staff stated that they needed a standing hoist for transfers. This type of hoist would be inappropriate and unsafe to use for a person who was non-weight bearing. Therefore the instructions contained within the risk assessment and what the person told us contradicted the instructions given to staff and therefore presented a potential for risk of harm.

Daily nurse handover records contained incorrect and inconsistent information to ensure that the monitoring of people's nursing care needs was effectively communicated from one shift to another. For example, we found nursing handover records located on the middle floor which recorded that there was no one currently receiving end of life care and no one with a pressure ulcer. However, it was evident that there was one person receiving palliative care and another with a grade two pressure ulcer to their heel.

This demonstrated a breach of Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there to be insufficient staff at all times to support the high number of people who required two staff to assist them with their personal care and when mobilizing using a hoist. This was evident from our observations and discussions with staff and relatives. People were observed being told to 'wait' when requesting support whilst staff attended to other people. One person who told staff she was thirsty and wanted a drink was told to wait while they attended to another person. A review of their fluid monitoring records showed us that they had not had a drink since the day before. Another person told us, "There is not always enough staff. Sometimes they are two short on a shift."

Staff told us there had been a high turnover of staff within the last 12 months. Staff were observed to be rushed and task focused and did not work at a pace that suited the needs of people isolated in their rooms.

Staffing numbers on the top and middle floor were inadequate for the number of people who required two staff required to support them with their personal care and hoists transfers. The numbers of staff on the middle floor reduced in the afternoon to one nurse and two care staff where there were nine people who required staff to support them with person care and transfers using the hoist. This staff told us meant they were unable to respond to meet people's needs in a timely manner. Staff also told us it was regular practice for staff who smoked to leave the floor without informing other staff they were leaving, leaving staff often alone to respond to calls for support from people who required two staff to assist. Two members of staff told us there are not always enough staff on duty and they were expected to provide the same level of care as when fully staffed. This was confirmed from a review of staffing rotas. We asked staff what the impact of this was on people who used the service. Staff told us, We are not always able to support people out of bed as they would like."

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed one staff member applying prescribed creams without the use of protective gloves, whilst another member of staff with gloves on and after applying cream then touch the handle of a hoist. Another care was observed to handle soiled linen without the use of protective gloves. This presented a risk of cross infection ad had the potential to put people including staff at risk of acquiring health related infections.

We observed carers supporting one person with mobilising using a hoist. We asked staff if the hoist sling used belonged to this person. Staff told us they used the same hoist sling for a number of people. This was identified as a serious risk of cross infection as the sling was applied directly to the lower part of the body, under the legs and around the sacral area. This posed a significant risk to people from cross infection.

We visited the laundry area. We found safe systems in place and operated to protect people from the risk of cross infection. Staff had available personal protective equipment and appropriate facilities throughout the service to enable them to adhere to safe handwashing procedures. This included the availability of paper towels and antibacterial hand wash.

The maintenance person demonstrated from a review of records a system in place for regular checks to ensure safety of the environment. For example, these checks included water temperature checks and checks for minimising the risk of Legionella. They also checked window restrictors on a monthly basis to make sure these were in good order. Bed rails were checked on a monthly basis to report any concerns to an external organisations for repair as well as checks on bath and mobile hoists. However, there was a lack of systems in place to regularly check clinical equipment such as syringe driver and suction machines. Nursing staff told us that there were no clinical equipment checks in place which would identify any faults so that they could be dealt with in a timely manner.

This demonstrated a breach of Regulation 15(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted the bannisters on the first and second floor were at mid-height and would not prevent a person easily leaning overt them and falling. The gate at the top of both of these sets of stairs was found to be at the same height and the catch only a handle which was easily opened. We noted that the gate did not always automatically close. There was no evidence of any assessment of this risk and neither any system in place for regular checks of this area. This could present a risk of falling and injury to people who used the service.

Inadequate

Is the service effective?

Our findings

Staff had attended Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs) training. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals.

However, as noted in regards to the giving of covert medication, we noted that not all the decisions taken on behalf of people who lacked capacity had been taken in line with the expectations of the MCA, an assessment of whether covert medication was in the person's best interest by those qualified to do so had not been carried out.

Consent to care and treatment was not always sought in line with legislation and guidance.
This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff told us they received a variety of training which included safe moving and handling techniques, first aid, food hygiene and infection control. They also told us they had opportunities to work towards national recognised qualifications such as Quality Care Framework. However, they also told us that given they worked in a nursing home they did not receive training in understanding the needs of people with complex health conditions such as those people diagnosed with Parkinson's and diabetes.

We observed support provided to people in eating their meals across all three floors during the midday meal. We found inconsistencies with regards to the level of support people were provided with. One person told us, "I give 100% for the food. I like traditional food. Today is Irish stew and you will not see much go back on the plates."

Staff were observed on the ground floor to offer the choice of two meals and where people did not like what was on offer alternatives were offered. However, this contradicted with what we saw on the top floor where one person told staff when offered their pudding, "I don't like custard you know this." The staff member took the pudding away and did not offer any apology or any alternative choice of pudding.

Where people had been referred to a dietician, recommendations had not always been followed. Action was not consistently taken to mitigate the risks to people from inadequate food and fluid intake. People who had been assessed as at risk of malnutrition were not sufficiently monitored to protect them from the risk of harm. Where recommended actions had been prescribed such as daily nutritional supplements, these had not been recorded as given. Where it had been recommended they be offered regular snacks and fortified milk shakes, there was no record of snacks and milk shakes provided. Two people's weekly weight monitoring records indicated they were consistently losing weight. Their food and fluid intake records showed large gaps where it was not evident that food, including snacks had been offered.

We observed one person who had three drinks placed in front of them but had not been supported to drink these. This person appeared to be restless and showing signs of dehydration, dry lips and skin.

Fluid intake records for eight people showed us that where daily consumption of fluid had been inadequate to maintain health and wellbeing, this had not been monitored and no action taken in response.

Daily food and fluid records contained a section for 'the person in charge' to sign that they had monitored these records on a daily basis and to record any action taken in response to any concerns. Of all the eight people's records we reviewed none of these monitoring records had been signed as checked. This meant that people who had been assessed as at risk of malnutrition and inadequate fluid intake were not sufficiently monitored to protect them from the risk of harm.

This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A review of daily notes and discussions with staff showed us that people had been supported to access other health professionals such as GP's, dieticians and speech and language therapists. People also had access to occupational therapists. However, in relation to appropriate assessment of people's needs and ability to access moving and handling equipment this specialist support was not always accessed in a timely manner for people at risk and in need of specialist equipment for mobilising safely.

Requires Improvement

Is the service caring?

Our findings

We received a mixed response from people when we asked if the staff who supported them were caring and compassionate and respected their dignity. Whilst some people told us, "I feel supported and love it here", I definitely would recommend it here the staff are good" and "I am well looked after here the carers are very good to me, I am really spoilt." Others said, "They don't always come when you call or they leave you waiting with no explanation" and "If you are nice to them [staff] they are nice to you. Some [staff] are better than others."

Whilst some staff were observed to treat people in a kind and compassionate manner this was not always demonstrated by other staff. People's care was not always planned and provided in a personalised, respectful manner. The majority of staff we observed knocked on people's doors before entering their rooms. However, this was not the case for all interactions observed. One member of staff who did not knock and realised we had observed this quickly then stepped back to knock on the door even though they had already entered the room.

We observed on the top floor people left alone in the communal lounge for up to an hour without any staff presence other than staff walking through the middle of the lounge to access corridors either side without acknowledging people. When staff were present and available there was little social interaction with people sitting in this lounge. One person residing on the top floor who asked for support from staff to go to the toilet we observed was told, "You will have to wait until after lunch." Also on the top floor we observed people calling out to staff and not responded to or their needs attended to despite staff walking past their rooms. This demonstrated a culture of task focused care with a lack of attention to quality care which endeavoured to meet the individual needs of people.

Apart from the two activities coordinators we did not observe care staff spending time with people other than to carry out personal care tasks and support with eating their meals. We observed interactions with people from some staff which identified a culture of task focused care which lacked attention to providing quality care which prioritised meeting the individual needs of people. Staff were observed when speaking to one another in corridors to refer to people as, "pad changes" and "feeds". One person was observed to ask for a drink three times before staff responded by telling the person, "You will have to wait, we are doing the tea trolley." However, we also observed some positive interactions between staff and people whilst they were supported with eating their midday meal. Staff sat at eye level and chatted throughout in a positive, enabling manner.

Staff interactions observed on the top and middle floor was not mirrored with our observations of the staff team deployed to the ground floor. Interactions between staff and people on this floor were observed to be warm, friendly and staff spent time talking with people in a friendly, un rushed manner. We also noted this was where the activities organisers spent the majority of their time.

We found notices placed on furniture within the first floor lounge which recorded the names of three people who had been referred to a dietician and contained information about their follow care as a result of

recommendations made. This meant that personal information about people was on display and available of everyone to view. This did not protect a person's confidentiality and protect their dignity.

This demonstrated a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Care plans were not reviewed regularly to reflect people's current care needs and lacked sufficient information and guidance to guide staff in mitigating risks to people's health, welfare and safety. For example, the care records in relation to the assessment and management of people's pain were poorly documented. There was a lack of wound care plans which evidenced regular monitoring of people's skin integrity. One person's records indicated they had a grade one pressure ulcer but this contradicted what was recorded in other areas of their care plan. This meant there was a lack of and inconsistent recorded guidance within care plans for staff to take action to prevent pressure ulcers for those people at risk and monitor improvement or deterioration of people at risk and those with identified pressure ulcers.

There was a lack of support provided to people which would evidence they had been involved in the planning and review of their care. People with capacity had not been given the opportunity to sign documents to evidence their consent to the use of bed rails. People without capacity had not been formally assessed for bed rails in use with best interest decisions made on their behalf by those qualified to do so. This meant that their human rights had not been considered.

One person identified as at the end of their life was seen to have their mouth open constantly and found to have a dry mouth, with dry lips and tongue. When we asked staff if they were able to tell us what if any plan of care there was in place to support this person with appropriate mouth care, they told us they had the day before spoken with a nurse suggesting this person have regular mouth care. The also told us that the response they received was, 'we will ask the relatives to provide some Vaseline for their lips'. This person had also been identified as not receiving support with regular, adequate fluid intake. Therefore we were not assured that action had been taken to support this person appropriately. We discussed this with the nurse on duty who instructed staff to provide regular sips of drink and this was then monitored.

We found people with finger nails ingrained with dirt and spectacles which required cleaning. The majority of daily care records we reviewed recorded; 'assisted with personal care' or 'all personal care given but did not detail exactly what personal care support had been provided by staff. Daily care records also recorded, 'assistance provided with continence care' or 'pad changed' but did not always detail exactly what support had been provided and whether the continence pad was wet or dry. We found the monitoring of people inadequate in mitigating any risks to people from ineffective bowel monitoring. We noted one person had no record of having had their bowels open for eight days with no evidence that this had been picked up by staff with action taken in response. Our discussions with staff showed us that there was no effective monitoring system that would highlight people who were at risk and so no action in response to those at risk evident. This put people at risk of not having their health and welfare needs met with health care support provided in a timely manner.

There were ineffective systems for assessing and monitoring people's pain. For people prescribed pain-relief medicines and who were unable to talk about their pain there were no pain assessments in place which would guide staff to recognise the signs with which the person expressed pain. For those people with pain relief medicines, to be administered as and when required, there was insufficient information to guide staff

as to when these medicines should be administered. We observed some people who appeared restless, unable to communicate verbally if in pain and appeared to be in discomfort, without evidence of any assessment of pain having been carried out.

One person we observed to receive very little in the way of any staff interaction and they remained isolated in their room throughout the day. Their care plan described them as often experiencing low mood and having good and bad days. However, there was no description of what constituted a good day and how staff could support them to experience improved quality of life. We noted there were several references to this person experiencing periods of anxiety and distressed behaviour. There were no recorded strategies with guidance for staff in managing this and supported the person appropriately to improve their quality of life.

This demonstrated a breach of Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The two employed activities organisers were knowledgeable and enthusiastic when describing how they supported the needs of people. They told us they supported people to access the community with trips to the sea front, garden centres and shopping. We observed one activities staff sensitively supporting some people on a one to one basis in their rooms. However, this was limited and failed to meet the needs of the high number of people who sat alone for long periods of time with little interaction and social stimulation. One member of the activities staff supported some people to be involved in painting a shed. On relative told us, "There are some activities but these take place mostly downstairs. This means that people rely on staff having the time to escort them."

A weekly plan of activities described a range of different group and individual one to one activities, aimed at meeting people's individual needs and interests. These included, exercise classes, trips to the shops, drawing and painting, card making and music sessions. One person told us, "I go on trips sometimes, in a bus. I've been put down for the trip to Felixstowe tomorrow." Another told us, "I really enjoy the music sessions when we have them. There was a bloke here yesterday playing the banjo." A relative told us, "[relative] very much enjoys the trips when they go out. It is good for them to get out in the fresh air." People also told us their views were listened to in the planning of activities. This meant that people were provided with opportunities to access activities to pursue their leisure interests and activities that promoted their autonomy and community involvement.

Inadequate

Is the service well-led?

Our findings

The registered manager responsible for the day to day management of the service was absent for an unspecified period of time. The service was being run by the provider's regional manager with support of a manager from another service.

Prior to our inspection we had received concerning information about the service provided. Safeguarding concerns had been reported to and investigated by the local safeguarding authority. A visit from the local authority quality and improvement team identified a number of concerns in relation to the level of staffing available, care planning, the management of medicines and the care of people at risk of acquiring pressure ulcers. The local authority kept us updated with the support that they were providing to the service to assist and lever improvement where needed. The deputy manager told us that the CCG was also planning to support the service with advice and support with regards to improving the systems to ensure the safe management of people's medicines.

In response to the concerns identified following the local authority quality and improvement team audit the provider submitted a service improvement plan with actions and timescales they had planned to ensure improvement to the safety and wellbeing of people who used the service. During our inspection we looked to see what action had been taken as a result.

We found at this inspection the quality and safety monitoring of the service was ineffective at identifying where the quality and the safety of the service was being compromised. We found the monitoring and auditing of people's medicines inadequate and in need of improvement. There was insufficient clinical oversight which monitored the quality of the nursing support provided to people with complex nursing needs and a lack of effective assessment of risk and action taken to mitigate the risks to people. For example, in monitoring and support for people at risk of inadequate food and fluid intake, at risk of acquiring pressure ulcers, risk of falls and effective systems for the control of infection. Current governance systems had not identified some of the shortfalls we identified at this inspection and had not fully addressed the issues raised by external stakeholders, staff and people who used the service.

Relatives of people who used the service and who had submitted formal complaints told us their concerns had not been dealt with in line with the provider's complaints policy. For example, timescales for responding to formal complaints had not always been adhered to. This was evidenced from a review of documentation provided to us.

The majority of people we spoke with including staff were complimentary about the management support provided. However, staff also told us that where concerns had been expressed about a lack of staff available at all times, staff going outside to smoke and leaving the floor without notifying colleagues, these performance issues had not been fully addressed and continued to impact on people having their needs met. The culture of the service was in the main task focused care which lacked attention to enhancing the daily lives of people and providing care which put the needs, wishes and choices of people at the core of how the service was run.

This demonstrated a breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always personalised, appropriate to meet their needs or planned to reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment was not always sought in line with legislation and guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure that the nutritional and hydration needs of people were monitored to ensure they received sufficient food and hydration to sustain life and good health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure that systems were in place to monitor and ensure infection control measures were adhered to by staff. There was a lack of equipment checks in place including checks on hoist slings and clinical equipment which would identify any faults so that they could be dealt with in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People's needs were not met by sufficient numbers of staff and suitably deployed at all times to meet their personalised needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have appropriate systems in place to ensure that the care and treatment of people was provided in a safe way to protect them from the risk of harm and inappropriate care.

The enforcement action we took:

We issued an urgent notice of decision to restrict the provider from admitting further people to the service and placed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality and safety monitoring of the service including clinical oversight was ineffective at identifying where the quality and the safety of the service was being compromised.

The enforcement action we took:

We issued an urgent notice of decision to restrict the provider from admitting further people to the service and placed conditions on the provider's registration.