HC-One Limited

Silverwood (Nottingham)

Inspection report

Imperial Road
Beeston
Nottingham
Nottinghamshire
NG9 1FN

Tel: 01159253699
Website: www.hc-one.co.uk/homes/silverwood-beeston/

Date of inspection visit:
15 January 2019
18 January 2019

Date of publication:
08 May 2019

Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 15 and 18 January 2019; the first day of inspection was unannounced.

Silverwood (Nottingham) is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Silverwood (Nottingham) accommodates up to 80 people in two separate buildings; one building provides residential care for up to 39 people and the other building provides nursing care for up to 41 people. There were 38 people with nursing needs and 32 people with residential needs who were in receipt of personal care at the time of our inspection.

At our previous inspection on 14 and 16 March 2017, the service was rated 'good' overall and the question 'Is the service safe?' was rated as requires improvement.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are registered persons. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection, we found improvements were needed to show how the risks around depression and potential self-harm were assessed and followed up. Improvements were also required to how risks associated with the provision of people's care were reviewed, analysed and reduced.

Care plans and risk assessments did not always accurately reflect people's care needs and any associated risks. Care plans and risk assessments were not in place for when people presented with behaviours that could potentially harm themselves or others.

Whilst some aspects of medicines management and administration were managed well, some improvements were needed to ensure medicines were consistently managed and administered safely. Some people had experienced medicines being out of stock. Records of medicines administration required improvement.

People did not always receive timely help from staff when they used their call bell. People also told us they had not always experienced timely help from staff and on one occasion this had compromised their dignity. We observed staff were not always deployed to ensure a staff presence in communal areas.

People told us they felt safe, however records did not demonstrate what actions had been taken to investigate one incident. Staff had been trained, and understood what actions to take to report any safeguarding concerns.

Equipment and actions to monitor, help prevent and reduce risks from pressure area damage had not always been used effectively. Monitoring and actions in relation to pressure areas and other healthcare needs, such as fluid intake and output also needed improvement. Care plans did not always reflect people's current healthcare needs to ensure staff understood how to provide them with consistent care.

People told us they thought staff were caring, however some people felt this was compromised when staff were too busy to spend time with them. Some improvements were needed to ensure people's experiences of staff were caring. Staff respected people's privacy and promoted their independence; we identified one occasion when a person's dignity could have been promoted better. People, and where appropriate, their relatives or representatives had opportunities to be involved in care planning.

Not everyone experienced responsive and timely care and some people did not have baths or showers as frequently as they would have preferred.

The service was kept clean and actions were taken to help prevent and control risks from infections. Other risks, such as falls risks and risks identified in the environment were assessed and actions taken to reduce risks from them.

The provider was keen to improve the service and sustain those improvements and learn from when things had gone wrong. The provider had action plans in place to help implement the improvements identified as required.

Staff were trained in areas relevant to people's needs and understood how to support people's diverse needs. Staff had systems in place to aid communication between them; the registered manager had in addition, identified some areas where communication could improve. Staff were supported by the registered manager, however arrangements for staff appraisals required improvement.

Improvements were needed to the systems and processes used to check on the quality and safety of services. This was because audits had not always been used as intended or had not always been effective at identifying shortfalls in the service.

Statutory notifications for abuse, or allegations of abuse, had not always been submitted in a timely manner as required.

People were offered a balanced diet and told us they enjoyed their meal choices. People also had opportunities to engage in a range of activities.

A range of other healthcare professionals were involved in people's care; referrals for other services had mostly, but not always, been made in a timely manner.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People's preferences regarding whether they preferred male or female care staff were known and respected. People had access to information in a range of other formats to help them understand their choices. A system was in place to help manage, investigate and resolve any complaints raised.

Advance care plans were in place to ensure people and their families and representatives if appropriate had the opportunity to express their wishes for their end of life care.

The building had been adapted to help meet people's needs, with such things as lifts and handrails along corridors. People had been supported to personalise their rooms to their own tastes.

The latest CQC rating was on display. The registered manager was viewed as approachable and wanting to improve the service. People and relatives felt they could be involved in the service and offer their views and opinions for consideration in the development of the service. Policies and procedures were in place to help with the governance of the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found one breach of the Care Quality Commission (Registration) Regulations 2009.

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

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

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

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Whilst some medicines management practices were safe, other medicines management practices were not safe. Improvements were needed to show how risks were followed up, assessed and monitored and accurately recorded in care plans and risk assessments.

Staff were not always deployed to provide care to people in communal areas or to ensure people received timely responses to requests for care.

People felt safe, recruitment processes checked staff were suitable to work at the service and staff were trained in, and aware of how to report safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Equipment and actions to monitor, help prevent and reduce risks were not always effective.

Staff received training in areas relevant to people's care needs. The premises were suitable for people and people's nutritional needs were met.

People's health needs were assessed. People had access to other healthcare professionals. People were treated fairly and the principles of the MCA were followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity had not always been maintained.

People told us staff were caring and kind and respected their privacy. Staff promoted people's independence and people were involved in decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive timely responses when they used the call bell system and did not always have a bath or shower as frequently as they would like.

Other preferences were met and people told us they enjoyed the opportunities to partake in activities. Information was provided to people in a format they could understand and systems were in place to manage and respond to complaints.

Is the service well-led?

Inadequate

The service was not well led.

Records, including care plans and medicines administration records were not always accurate or complete or stored securely. Systems to monitor the quality and safety of services and to identify improvements were not always used effectively to secure improvements, nor did they always identify shortfalls. Statutory notifications of allegations of abuse had not always been submitted in a timely manner as required.

A registered manager was in post. The registered manager and provider wanted to improve the service and were committed to working in an open and inclusive style and in partnership with other agencies.

Silverwood (Nottingham)

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 checked 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 comprehensive inspection took place on 15 and 18 January 2019; the first day of inspection was unannounced. The first day of inspection was completed by one inspector, an assistant inspector, a specialist professional advisor whose area of specialism was nursing, 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 second day of inspection was completed by two inspectors and an assistant inspector.

Before the inspection visit we looked at all the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about.

We also checked whether Healthwatch Nottinghamshire had received feedback on the service; they provided us with some feedback, however this had been received prior to the current inspection timeframe. Healthwatch Nottinghamshire is an independent organisation that represents people using health and social care services.

This inspection was prompted in part by a pattern of safeguarding investigations and statutory notifications concerning serious injury. The information we held about the service before our inspection indicated potential concerns about the management of risk in the service. These included management of risks associated with people's care needs, including pressure ulcer care and continence care.

As this was a responsive inspection we did not ask the provider to complete a Provider Information Return (PIR) prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took the information from the PIR completed by the provider in 2017 into account when we inspected the service and made the judgements in this report.

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 spoke with nine people who used the service and five relatives. We also spoke with five management staff including, the registered manager, the clinical lead, the unit manager, the area director and area quality director. In addition, we spoke with one senior care staff, a registered nurse, three care staff, the housekeeper, activities coordinator and the cook.

We looked at the relevant parts of seven people's care plans and six personal care records, and reviewed other records relating to the care people received and how the service was managed. These included risk assessments, quality assurance checks and governance systems, medicines administration records and staff training. We asked the provider to send us information on their policies and procedures and action plans; this was received.

Inadequate

Is the service safe?

Our findings

Records showed staff were aware a person was in low mood and had expressed suicidal thoughts and potential suicidal plans. We were concerned as no referral had been made to their GP or other relevant health professional to review their care. In addition, their care plan and risk assessments had not been updated to reflect the potential risks for this person to harm themselves. Neither had a formal assessment of the person's mood been completed and care planned for. We made the registered manager aware of our concerns and made a safeguarding referral to the local authority. On the second day of our inspection the registered manager had made a referral to the GP, completed risk assessments and a formal assessment of the person's mood; this recorded the person was depressed. Risks around depression and potential self-harm had not been appropriately assessed and steps taken to reduce risks before we made the registered manager aware.

We found other risks had not been identified and not reviewed to see if any further actions could reduce risks. For example, we found one person's catheter had become dislodged on five occasions during personal care in July and August 2018; this was of concern and we could not see how this had led to any review of the care the person received. On the second day of our inspection staff told us this had been due to the person's choices of sling, however we felt this area of care required further review and risk assessment. We made the local authority safeguarding team aware of our concerns. Shortly after our inspection, the provider also sent us an updated care plan that included advice to staff to use the sling carefully as it had been known to dislodge the person's catheter.

We heard another person in their room calling, "Help me." We went to see the person and found them in a slumped position in their bed. They told us they were uncomfortable. They had a call bell pendant in bed next to them and we prompted them to press this. Call bell systems are designed to alert staff when people require assistance. We waited with the person for over 5 minutes, when no staff arrived we went to find a staff member to assist the person. Staff then assisted the person into a more comfortable position in bed. The staff member pressed the call bell and told us it was not working; they told us they would regularly observe the person if they could not get the call bell to work properly. On the second day of inspection the registered manager told us they had checked all call bells and told us they were working. They told us the person's call bell request had been registered on the system, however it was unclear as to why this was then not responded to. We were concerned the call bell had not been effective in obtaining staff support to this person on day one. Systems to reduce risk to this person had not always worked effectively.

For other people, their care plans had not always been updated to show changes to their care needs. For example, one person had been receiving medicines with the assistance of a syringe driver. Syringe drivers are used to supply a regulated and constant supply of medicine through an injection. The person no longer used the syringe driver, however their care plan had not been updated to reflect this change. People were at risk of inconsistent care as care plans were not up to date with people's current needs.

We also found that whilst in use, the syringe driver had been re-sited and the reason for this had not been recorded. Incidents of this nature should be reported and investigated to ensure lessons are learnt and

future mistakes can be prevented. We were concerned this had not happened. We made the registered manager aware of the record so they could investigate. They told us they were investigating the possibility that the equipment needed to be re-sited due to the wrong type of equipment originally being used.

We reviewed care records for two people who had expressed some behaviour that could potentially cause harm to themselves and had also harmed others. These care records were designed to record information about a type of behaviour, including what happened before the behaviour, what actually happened at the time, and what occurred after the behaviour. They are designed to help understand what the person is communicating and how care can be provided to help promote positive outcomes for the person. The behaviour incidents reviewed for both people had resulted in other injuries to a person, a visitor and staff. Neither person had a positive behaviour care plan in place or associated risk assessments that detailed these known behaviours. We could not see how the information contained in the care records had been used to effectively review people's behaviours and evaluate their care with the view of achieving positive outcomes for them and reducing risks. Shortly after our inspection the provider told us they had arranged support for staff to enable improvements in behaviour management and monitoring.

We observed one person was supported by two care staff for pressure relieve. Care staff suspended them in a hoist for three minutes and provided reassurance for them during this time. We asked staff about this and they told us they had been told to undertake this technique by the tissue viability nurse. There were no details about this technique in the person's care plan. We were concerned that this was not a safe use of lifting equipment and asked the registered manager for more details. They told us it had been advised by a visiting health professional and told us they would send through more information to provide assurances on this technique. However, this was not received. Therefore the provider was not able to provide assurances that this use of lifting equipment, and this technique used was safe.

We found that whilst one person's insulin was appropriately stored in a fridge, the dates the medicine had been dispensed went back to September 2018. Whilst this medicine was still in date and therefore posed no harm to the person, the stock rotation system in place for this medicine could improve. The nurse told us they had made arrangements for the old stock of this medicine to be removed.

We found another person received pain relief medicines from a trans-dermal patch. These are medicine patches that adhere to a person's body. There was no chart showing the administration site and removal of the patch and there was no record that daily checks were taking place to ensure the patch remained in place. Daily checks are important where trans-dermal patches are used as they can be accidentally removed resulting in ineffective pain management. This meant risks associated with medicines were not always safely managed.

Checks on medicines administration record (MAR) charts showed some medicines were out of stock and had not been available for people to take as prescribed. For example, one person's nutritional supplement prescribed to help prevent against the risks of malnutrition had been out of stock from 29 December 2018 to 10 January 2019. A medicine prescribed to help this person with urinary and bladder difficulties had been out of stock for three consecutive days in January 2019. Another person had been out of stock of their allergy medicine since 2 January 2019 and another person was out of stock of their medicine for epilepsy between 24 to 26 December 2018. Medicines were not always managed well and people were at risk of not receiving their prescribed medicines.

We found two people had been prescribed a topical (applied to the skin) cream, to be used as a barrier cream to prevent tissue damage. However, there was no topical MAR chart for these creams. This meant there was no record to say it had been applied as prescribed. We checked a sample of other topical MAR

charts and found gaps in the records. For example, one person was prescribed a cream to be applied three times a day. Records showed it had only been applied once a day and this had not taken place every day, and records included a gap of 11 days when no cream had been applied. This meant the provider could not provide assurances topical medicines had been applied as prescribed.

We found some handwritten medicines administration records had not been consistently checked and signed by two staff. Having handwritten administration records created and then checked by appropriately trained members of staff is recognised good practice and reduces risks associated with medicines; this had not been in place.

We found protocols were mostly in place to help staff make consistent decisions when people required medicine to be given 'as required' rather than at set time intervals. However, we found one protocol was not in place as required. This meant people were at risk from not always receiving their medicines consistently.

These are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and relatives told us they thought there were not always enough staff. One person told us, "There's not enough staff; you can wait ages for the toilet, maybe 40 or 50 minutes and I get left with wet trousers." Another person told us, "Sometimes they seem to be a bit short [staffed]; they are getting more staff; you don't wait too long." Some relatives were concerned staff were often not present in communal lounge areas to provide care when people needed it. Our observations showed staff presence in communal areas varied; one person in a communal lounge area waited up to 10 minutes before care staff came into the area and they could ask them for assistance. At other times staff were present in communal areas. On day two of our inspection staff maintained more of a presence for people in communal areas. Shortly after our inspection the provider sent us information that said its policy was for staff to be where people's needs were.

Staff views on staffing levels were mixed. Some staff told us they felt there were enough staff, however other staff told us there was not enough staff and told us this was a concern to them. They felt it contributed to staff not wanting to work at Silverwood (Nottingham) and also made them feel anxious. One staff member told us, "We need more staff, we cannot do everything we need to do and the paperwork; I go home and have sleepless nights when I remember what I've not done; [managers] need to address how much time we need, and staff sickness often creates problems to cover."

The provider had an assessment tool to help them calculate the number of staff needed to meet people's needs. However, people told us they did not always experience timely care. For example, they told us staff did not always respond to the call system when they used it. One person told us, "Staff give you a buzzer to ring and nobody comes." Another person told us about a call bell in the lounge area, they said, "There is a buzzer over there but there is no response to it." Following our feedback on day one of the inspection, the provider commenced monitoring of call bell response times. These showed some people had experienced waits of in excess of 15 minutes and on two occasions over 30 minutes in the two days of call bell monitoring. We also observed times when people in communal areas did not see staff for periods of time. This meant that although staffing was planned to try and meet people's needs, this did not always succeed and staff were not always deployed effectively to ensure communal areas had staff presence and people received timely responses to call bell requests.

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

Whilst people and relatives told us they were assisted to move safely, one person told us that their hand had been bruised when staff assisted them to move. They told us they had informed the senior carer who made a note of it. We found body maps for another person had recorded two occasions when unexplained bruising had been found on their body, in addition to bruising being found when they were admitted to the service. For one of the bruising incidents the unit manager was able to show us the GP had been involved in reviewing the bruising. However, for the other record of bruising, they were not able to show us what action had been taken. Without evidence that medical advice and further investigation into the potential source of the bruising, the provider could not provide adequate assurances that people had been safeguarded appropriately.

People told us they felt safe with the care staff provided. One person told us, "Staff look after us, they keep us safe." A couple of people told us they had felt worried when another person had entered their room at night; however, they told us staff were good at managing this and it had not happened often."

Staff told us and records confirmed they had been trained in how to identify potential abuse and how to report it. Staff we spoke with understood what signs could indicate a person may be at risk of, or had potentially experienced abuse and knew how to report their concerns. Prior to our inspection, we had received information from the local authority safeguarding team concerning the outcome for nine safeguarding investigations, some of which had recorded the allegations of abuse had been 'substantiated' or 'partially substantiated'. In addition, the safeguarding team had made recommendations for the provider to implement following these 'substantiated' enquiries and other safeguarding enquiries. The provider is required to submit statutory notifications to CQC for allegations of abuse; these had not been submitted as required.

We did also find some areas of medicines management were well managed. Staff involved in administering medicines, did so safely and in an unhurried manner. Medicines, including thickening powders and food supplements were stored safely, at the correct temperature, and liquid medicines and eye drops were dated when opened. Management arrangements and checks were in place for medicines subject to additional controls. The sharps bin (used for the safe disposal of sharps, for example, needles) was not overfilled and was dated when brought into use.

A number of people were prescribed pain relief medicines and their care records detailed if they could communicate their pain levels. For people not able to communicate this, there were descriptions of non-verbal behaviours that could indicate people were in pain. This would help to ensure people not able to communicate their pain levels received their pain relief medicines when needed.

Some people were prescribed certain medicines that were required to be taken at set times before food; we saw arrangements were in place and followed by staff to ensure these medicines were given as prescribed. One person received a vitamin injection at set time intervals. Staff had scheduled in the next due date to ensure the administration of this medicine was forward planned. Where people had their blood glucose levels monitored, we saw these monitoring records were fully completed and the site of administration was also stated. This follows recognised good practice. In addition, these people had rescue care plans attached to their MAR charts for staff to follow should it be required.

The provider had identified improvements were needed to manage some malodour in the nursing unit. Records showed plans were underway to replace areas of existing carpet to eliminate the odour. In the meantime, the provider had used equipment to help neutralise and manage any malodours.

People told us they thought their home was kept clean. One person told us their room was cleaned every

day. We saw communal areas and people's rooms were clean and tidy and there was adequate provision for hand washing and adequate supplies of gloves and aprons, which staff were seen to use. Sluice rooms were clean and provision was made to maintain the hygiene of reusable continence aids. Cleaning schedules showed all areas of the home were systematically cleaned to help infection prevention and control. Actions had been taken to ensure people were protected from the risks associated with infection.

People had access to any equipment they needed, for example equipment used to help people mobilise. Risk assessments were in place for people who were at risk from falls, pressure ulcers, choking or when people required assistance to mobilise. Any falls were analysed and equipment used to help prevent and reduce identified risks from falls. One family member told us, "[My family member] has had a fall; staff got the doctor in and checked him over and they phoned me." Actions were taken to assess some risks.

We saw environmental risks had been considered and actions taken to help keep people safe. For example, areas of the building that presented risks to people, such as where cleaning materials were stored, were kept locked. Risk assessments were in place for foreseen emergency situations. For example, personal emergency evacuation plans (PEEP's) were in place for each person, which showed what assistance people would require should an emergency evacuation from the building be required. Records also showed a fire risk assessment was in place and systems designed for use in an emergency, such as fire alarms and emergency lighting were regularly tested. In addition, routine safety checks and servicing of equipment, such as lifts and hoists, were regularly completed. Some people and relatives told us they were sometimes concerned that furniture or wheelchairs were placed in front of fire escape doors. We observed staff moving a chair that had been placed in front of a fire door in a main communal lounge. This demonstrated staff were aware and took action to keep the fire doors free of obstruction.

The provider told us they were disappointed in the concerns found at our inspection; they took prompt action to address the concerns we raised with them. However, other professionals such as the local clinical commissioning group (CCG) and local authority safeguarding and quality and monitoring officers had previously highlighted concerns similar to those we found. We were concerned that the provider had not been able to fully improve based on the previous input of other professionals, and their own scrutiny. We were also concerned the issue we have described in this section regarding the re-siting of a syringe driver was not identified for investigation prior to our bringing it to the attention of the provider. However, the provider felt the improvements needed would now be achieved and sustained with the recruitment of a new deputy manager and a new clinical lead. This showed the provider was willing to learn from when things went wrong and was keen to improve the service.

Requires Improvement

Is the service effective?

Our findings

When people used equipment to help prevent pressure ulcers we found this had not always been used effectively and in line with best practice guidance. One person had a pressure ulcer and other wounds and was at very high risk of developing further pressure ulcers. They used an air pressure mattress to help prevent pressure damage. The air pressure mattress needed to be set at a certain pressure to help remain effective in preventing pressure ulcers. However, records for one day showed this had been set incorrectly and at a lower than required pressure setting. Due to a lack of records from the start of January 2019, the provider could not assure us the air mattress had been set correctly over this time period. Another person had pressure damage and was being cared for on an air mattress. Records showed it had been set 10 kilograms too low on one date and then it was adjusted to the correct setting. As there were no records made for the preceding four days, the provider could not assure us this person's air flow mattress had been used correctly. Not all care staff we spoke with were confident in how they would identify any concerns with the air mattress settings. One care staff member told us, "The nurses deal with [air mattresses]." This meant best practice guidance to help prevent pressure ulcers was not always followed. This was because equipment used to help prevent pressure ulcers was not always used effectively in line with best practice and standards so as to mitigate risks to people.

Other actions taken to monitor pressure ulcers were not always effective and followed best practice guidance and standards. This was because photographs taken to monitor wounds and to track any healing or deterioration were not clear enough to enable this to be done. In addition, photographs did not include measuring tape, despite the registered manager stating this was available. This meant wounds were not always assessed and monitored in line with best practice standards to reduce risks.

Actions to help ensure effective monitoring of people's other healthcare needs were not always in place. Where people used a catheter or convene, it is good practice to monitor their urine output to ensure any urine retention can be identified at an early stage. This had sometimes been reflected in care plans, for example one person's care plan stated, 'staff to monitor urine collection and encourage fluid intake to reduce risk of blockage and infection.' However, for this person there were no monitoring records for their urine output. Another person with a catheter also had no urine output monitoring. In addition, this person had also experienced a previous bowel obstruction and as such bowel movements should have been monitored to ensure early detection of any recurrence. This was not in place. People's healthcare conditions were not always effectively monitored in line with best practice and standards. There was a risk changes in their healthcare conditions would not be effectively identified, assessed, monitored and reduced.

Some people had their fluid intake monitored. For one person, a fluid target had not been recorded on their fluid chart. The total fluid intake had not been calculated per day and the charts had not been reviewed by a senior or a nurse. Their charts showed they had received between 720mls and 900mls for a sample of days preceding our inspection. As there was not a target fluid level stated, or any evidence of the person's fluid intake having been reviewed or additional fluids encouraged, the provider could not assure us this person received sufficient fluids. Fluid monitoring did not demonstrate best practice guidance was followed and risks to people were not always mitigated. We fed this back to the provider on day one of our inspection; on

day two they told us they had set fluid targets and totalled all the fluid charts. They told us they had identified one person who they had referred to the GP for a review of their fluid intake.

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

People told us they felt staff were trained and had the skills to support them. Staff told us and records confirmed they received training in areas relevant to people's needs. We saw this included training in such areas as dementia care, mental capacity act and deprivation of liberty safeguards training. Staff told us they felt supported by the registered manager and their supervision was useful. Supervision provides staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development. The registered manager had taken action to arrange supervision meetings with staff to cover some of the improvements needed as a result of the concerns we had discussed with them from day one of our inspection. Records were not available to show staff had been provide with a staff appraisal. An appraisal is a formal assessment of the performance of staff and usually occurs on an annual basis. We were told this was because the system to manage staff appraisals had not been updated with the new registered manager's details. We were told the provider was taking action to ensure this was updated.

The 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 so that they can receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met; we found that they were. The service had policies in place that covered the MCA and making decisions in a person's best interests. Where appropriate, applications for DoLS authorisations had been made and the registered manager had a system in place to oversee the management of them. Care plans showed any best interest decision making was specific. Staff we spoke with understood how the MCA and DoLS applied to people they cared for. However, we found one person received their medicines covertly. Although records showed the GP had decided to administer medicines covertly, there was no capacity assessment recorded and associated best interest decision making to evidence the MCA had been followed.

We saw key staff from all areas of the service met with the registered manager each day to discuss important issues and changes. We observed one of these meetings and saw information was effectively shared between staff members. Some staff told us communication could also improve. For example, the registered manager told us they wanted to improve communication when people transferred their care from the residential side of the service into the nursing side. Some systems worked well to ensure staff worked well across the service and other systems had been identified for further development.

Staff were knowledgeable on people's diverse needs and told us how some of these needs were met. For example, what music people liked to listen to. The provider's equality and diversity policies and procedures set out the provider's commitment to meeting people's diverse needs. These were up-to-date and showed an awareness of the protected characteristics under the Equality Act.

People and relatives told us they were satisfied with the food provided. One person told us, "The food is

pretty good; there's a nice variety." Another person told us, "The food is good; there is a good menu and staff put the daily menu outside the door." We observed people were visually shown the different choices of meals available. This is good practice, especially for some people living with dementia, who may be able to visually recognise choices better than being only offered verbal choices. We saw different meal choices were available for when people had a vegetarian diet. We saw adaptions were used to help people maintain their independence with meals and drinks, for example lidded cups were used for some people's drinks. Staff provided assistance to help people with their meals when this was needed. People were offered a balanced diet.

People told us they had access to other healthcare professionals when needed. Relatives and people told us about referrals to other healthcare services that had been made. Records showed a range of healthcare professionals were involved in people's care. Most of these were made in a timely manner, however we found a referral for a dietician had been identified as needed by a visiting professional; this should have been identified and action taken to refer to the dietician by the provider.

Actions had been taken to adapt the premises to the needs of people living at Silverwood (Nottingham). Handrails and lifts were installed to help people mobilise. We saw people enjoyed spending time in the different lounge areas around the building. Some of these had been designed to include features people living with dementia may recognise, such as a pub bar. Corridors on the residential side incorporated seating areas at end points. This design can help people rest during a walk as well as act as a focus point for people to reach. The garden had been designed with features people could enjoy in good weather or enjoy looking at in colder months. For example, an aviary was positioned outside a lounge area for people to watch the birds. The premises had been adapted, designed and decorated to help meet the needs of people using the service.

Requires Improvement

Is the service caring?

Our findings

Some people and relatives told us they were concerned that people's dignity was not always maintained. As stated elsewhere in this report, one person told us they experienced an episode of incontinence whilst waiting for staff to assist them to the toilet. A family member told us they felt their relative sometimes didn't look as smart as they would want them to. We observed another person who had not been supported in line with the provider's expectations to maintain their dignity. We discussed this with the provider and they took steps to review how this person could be further supported.

People told us staff were kind and caring, for example, one person told us, "The staff are lovely." One person told us they thought staff were caring, but that they were slow to help them. Another person told us staff would sit and chat, but only if they had the time. One person said, "I don't have conversations with staff, they are always too busy." Our observations showed activities staff interacted well with people and this demonstrated a caring approach. However, we did not always see care staff took opportunities to demonstrate a caring approach in their interactions with people. For example, we observed periods of time when staff stood and chatted amongst themselves rather than taking the opportunity to sit and interact with the people in the lounge area. At another time, we observed a person assisted with their meal and the care staff member made no conversation. These are example of how care staffs' caring interactions with people required improvement.

People told us they felt staff respected their privacy. For example, one person told us, "Staff knock on the door before they come in." Staff we spoke with told us they would always take measures such as this to respect people's privacy. One staff member told us, "I always close the door and the curtains when I am supporting people with their personal care." Staff were respectful of people's privacy.

We saw staff promoted people's independence, for example people had access to lidded cups for drinks; this ensured people could have drinks themselves without the risk of spilling liquids. One relative told us, "[My relative is very independent and staff do help them with that." During our inspection, we saw people received visits from their relatives. People's independence and their relationships with relatives supported.

Whilst not all people and relatives could recall being involved in the person's care plan, one person told us, "I've talked about my care plan to staff and my [relative] and it gets reviewed." Another person told us, "You can read your own file and change it if anything is wrong or incorrect." We saw staff sitting with a person and their relative and reviewing their care plan with them. From reading care plans we could see these were personalised. Records showed where care plans had been reviewed with people and their relatives. The provider had taken steps to involve people in their care plans.

Requires Improvement

Is the service responsive?

Our findings

As reported elsewhere in this report, some people told us they sometimes had to wait for staff to assist them when they had used their call bell. As a result of our feedback on day one of the inspection, the provider showed us they had started to monitor the response times to call bells. We reviewed these on day two of our inspection. These records showed the best response time to a call bell request was four minutes and this had been achieved on 20 occasions. However, there were 19 occasions where people had waited over 15 minutes for a response, this included two occasions where people had waited over 30 minutes. The records of call bell response times showed people did not always receive a timely response to requests for help. The provider told us they would continue to monitor call bell response times and investigate when a call took any longer than 3 minutes to respond to.

Whilst some people told us they could have a bath or shower once a week, some people told us they would prefer to have baths and showers more frequently than they currently experienced. Some relatives told us they were concerned their family members were not being assisted to bath or shower on a weekly basis at all. We reviewed a sample of six personal care charts that recorded when people were offered baths and showers from the start of January 2018. One person whose care plan stated they wanted a bath or a shower once a week, had a gap of 12 days before they had a bath. Another person had a gap of 11 days before records showed they had had a bath. From the other records, one person's personal care records had not been completed and the records for another person stated they had received a bed bath. The records for the other two people indicated they had had baths or showers on two and three occasions in January. The provider could not provide assurances people were assisted to bathe or shower on an at least weekly basis. However, shortly after our inspection the provider told us that all people had been supported to have a bath or a shower in the last seven days.

People told us they were asked whether they preferred female or male carers to help them with any personal care and that staff understood them. Although, one person told us they felt agency staff knew them less well. They said, "The regular staff know what they are doing, it's a bit difficult for me when they have agency staff." A relative told us, "Staff know what [family member] likes; most of the time they seem happy, they say how lovely the food is and the staff are." Information to help staff understand more about people and their lives varied in the care plans we saw. We saw staff knew people's interests and people had been supported to personalise and decorate their rooms to reflect their own interests and tastes. When people spent time in their rooms they had access to music or television programmes to suit their preferences.

People told us they appreciated the opportunities to partake in activities with staff and other visiting activity providers. However, one family member told us there had not been any activities for 'weeks' prior to our inspection. One person told us, "Staff get entertainment in, we do games and all of that." Another person told us, "I've been playing dominoes; staff get to know about you, we do different craft things." Whilst another person said, "I do like to do things, I get bored. If staff come and say we're going to do this, I'm pleased." We observed staff organising games with people during our inspection. We also saw a person visited people and offered sensory activities. The registered manager spoke about developing activities further with a dolls house renovation project. People enjoyed the opportunities to do activities at the

service.

The provider had looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. Policies and procedures were available in different formats to help people who may for example, need information in a large print format. Information was available in different formats to help people understand it.

People and relatives could not recall having received information on how to make a complaint. However, they told us they would feel comfortable talking with senior staff if there was a problem they needed to resolve. They told us they thought any complaint would be dealt with fairly. A touchscreen facility was available in the reception for people to give feedback, in addition information on how to complain was on display. The provider had a complaints policy and procedure in place to ensure any complaints were investigated and managed. We saw any complaint made had been investigated and any outcome or resolution recorded. Complaints were managed in line with the providers policy and procedures.

The registered manager told us no one was in receipt of end of live care at the time of our inspection. We saw some advance care plans for the provision of care towards the end of a people's lives were in place. These showed relatives had been involved in discussions when appropriate and the care plans recorded how people wished to be cared for at this stage in their life. Advance care planning for end of life care helps to ensure people's needs are met at that time.

Inadequate

Is the service well-led?

Our findings

The provider told us they had identified some improvements were required at Silverwood (Nottingham). They told us they had made the service a 'focus' home. This meant that for approximately the eight weeks prior to our inspection, the service had received additional support from the provider to help it improve. The provider had also met with representatives from the local clinical commissioning group and the local authority who had competed quality assurance audits at the service during this time. In addition, the provider had recently completed their own internal inspection of the service and had rated it as 'requires improvement' on 6 December 2018. This internal inspection had identified areas for improvement that covered most of the areas we found concerns with at this inspection. However, the internal inspection had assessed all statutory notifications had been submitted as required, when statutory notifications for allegations of abuse had not been submitted as required. This meant that the systems used by the provider to assess, monitor, mitigate risk and improve services had not always been effective at identifying shortfalls in the service.

In support of working towards the improvements identified as required by the internal inspection, the provider had a range of systems to check on the quality and safety of services. These were designed to identify shortfalls and identify improvement actions. However, we were concerned that these had not always been used effectively. This was because an audit designed to make daily checks to ensure the safe management of medicines had not been used as intended. We reviewed the daily audit checks for medicines on the nursing side and found it had only been completed on five occasions since 24 December 2018 to the first day of our inspection. The shortfalls we found and reported on elsewhere in this report could have been identified and remedied by the provider, had the audit tool been used as intended. We were concerned that despite the provider's own internal inspection identifying improvements were required to medicines management, the daily audit deployed to help make improvements had not been used as intended. This meant that systems and processes designed to assess, monitor and mitigate risk and improve services were not operated effectively. We were concerned the provider had not taken all steps to improve the service as they themselves had identified was needed.

Prior to our feedback to the registered manager on 15 January 2019 that we had observed one call bell had not been effective at obtaining timely staff attention, and feedback from other people that they were waiting for staff to attend call bells, there had been no monitoring of call bell response times. On day two of our inspection, the provider had implemented this monitoring and this showed there were 19 occasions where people had waited over 15 minutes for a response and this included two occasions when people had waited over 30 minutes for a response. Whilst the provider told us they would continue to monitor and investigate whenever responses took longer than three minutes to respond to, we were concerned that the provider had not identified themselves that people had not always received a timely response to call bells response times. Steps to improve the service had not always been taken.

As reported elsewhere in this report, not all people received a bath or shower as regularly as they would like. The provider had not identified from audits of care records that service users were not recorded as having frequent baths or showers. Whilst the provider, shortly after our inspection told us all service users had been

given a bath or shower of their choice in the week following our inspection, we were concerned that the provider's audits of care records had not identified this as an area for improvement prior to us raising it with them. Systems and processes were not always effective at making improvements to the quality and safety of people's care.

As reported elsewhere in this report, during our inspection on 15 January 2019 we observed staff were not always present in communal areas where people were. We observed one person required care during this time. Shortly after our inspection the provider sent us information that said it's policy was for staff to be where people's needs were. Whilst we saw staff were more present to meet people's needs in communal areas on day two of our inspection, on day one this had not always happened. People's needs had not always been met by staff in line with the provider's policy.

We found one person was prescribed insulin. The administration instructions on their insulin stated they were prescribed 10 units twice daily, however their medicines administration record (MAR) chart had been changed by hand to read 14 units twice a day. The handwritten change was not signed or dated. This is not safe practice as the MAR chart should correspond with the instructions on the medicine. We bought this to the attention of the nurse who told us the insulin had been increased on the instruction of the GP. They spoke with the GP and obtained a new prescription later that day. Records were not always accurate and up to date.

On day one of our inspection, we discussed one person's wound dressing routine with the nurse on duty. They told us they did not know why the person's wound dressing was being changed more frequently than professional advice appeared to recommend. On day two of our inspection, we were shown evidence that the wound was being changed in line with advice and guidance from other professionals. We also discussed our concerns that a person's catheter had been routinely changed more frequently than the care plan stated. The nurse we discussed this with had no clinical rational for why this was being changed at a different frequency to that specified. However, on day two, the registered manager provided an updated care plan that provided a clinical rational for why the person's catheter should be changed at the frequency it had been. We were concerned not all staff with responsibility for people's care had a consistent understanding of people's care needs and that care plans and records were not always up to date to enable a consistent understanding of people's care needs.

Records of when wound dressings had been changed to help with the management and healing of wounds and to relieve pressure areas through repositioning people were not always complete. For one person who required a daily change of dressing there were three consecutive days when no record had been made to confirm the dressing had been changed in line with the care plan. Another person who required repositioning every two hours had no repositioning charts completed for three consecutive days. Due to the lack of record keeping the provider could not assure us that these people received effective care in line with their care plan.

In addition, records of people's care and treatment were not always accurate and complete. We found examples, as reported elsewhere in this report where people's care plans had not been updated to reflect their current needs. We found gaps in people's repositioning, personal care and medicines records. In addition, records had not always been stored securely. This is because cabinets in the communal dining room containing people's personal care records had been left open on day two of our inspection. Records were not always accurate or complete and stored securely.

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

The provider is required to submit statutory notifications to CQC. Notifications are changes, events or incidents that providers must tell us about. Not all relevant statutory notifications for allegations of abuse had been submitted as required. These allegations of abuse occurred between July and December 2018. We were concerned the provider's own internal inspection dated 6 December 2018 did not identify statutory notifications had not been submitted for these allegations of abuse. We discussed this with the registered manager on day one of our inspection. The registered manager told us they would complete an audit and submit the missing statutory notifications. Shortly after, we received seven statutory notifications for allegations of abuse. Not all statutory notifications for allegations of abuse had been submitted in a timely manner as required.

This was a breach of Regulation 18 the Care Quality Commission (Registration) Regulations 2009.

A registered manager is required and was in post at Silverwood (Nottingham). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider's home improvement plan dated 5 December 2018 identified what improvements had been required and what actions had been taken to improve the service between August to December 2018. This showed actions had been taken to improve medicines management, care plans and monitoring records for care, air mattress settings and pressure equipment use and statutory notifications. We were therefore concerned that the issues found at our inspection, because they were the same nature of concerns as detailed on the home improvement plan, indicated that the actions taken had not been effective or that any improvements made, had not been sustained. We discussed this with the registered manger, area quality director and area director. They told us the new deputy manager, who had started in the role one week before our inspection, and the new clinical lead, who had been in the role for approximately three weeks, would help ensure improvements were made and sustained. In addition, the provider had started supervision with staff so they understood what records of care needed to be completed. Shortly after our inspection, the provider sent us an updated action plan. This reflected the actions taken in response to our inspection feedback.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had clearly displayed this in the home and on their website.

People, relatives and staff told us they found the registered manager approachable. One person told us, "This new manager is very approachable." A relative told us, "The manager has got time to chat, sort things out; they are helpful." Staff were of the view the registered manager was fair and approachable. One staff member told us, "[Registered Manager] is very sociable; communication is really improving." Staff we spoke with enjoyed the work they did. One staff member told us, "I am very happy working here."

The registered manager had taken steps to involve relatives in the service. Records showed meetings were held with people. We saw people had had the opportunity to share their views on mealtimes, housekeeping, cleaning, activities and the care they received. Whilst some relatives did not know about relatives' meetings, some relatives told us these did take place and records confirmed these meetings were held. They showed new initiatives and developments for the service were discussed; these included ideas to develop a shop, a library area and further develop a lounge into a vintage pub. Relatives were given the opportunity to give their views on these ideas as well as other aspects of the service such as mealtimes, housekeeping and

laundry services. There were opportunities for people, their relatives and staff to be engaged and involved with the service.

People and relatives told us they had access to a range of other services. These included healthcare services such as GP's, district nurses and chiropodists as well as hairdressers and visiting activity providers. The service worked in partnership with other agencies to help achieve good outcomes for people.

Policies and procedures for the governance and operation of the service were in place. Accident and incident reports were analysed by the registered manager and for certain events, such as falls; this information was analysed and monitored for any trends.

Other audits were completed on such areas as infection prevention and control, health and safety and on the safety of the environment. We saw that equipment was regularly serviced and a fire risk assessment was in place.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents CQC statutory notifications had not always been submitted in a timely manner as required. 18.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to people's health and safety were not always assessed and not all reasonably practicable steps to mitigate risks were taken. Equipment was not always used correctly. Not all medicines were managed properly and safely. 12.

The enforcement action we took:

We served a notice that required the provider to follow an action plan to ensure improvements at the service were implemented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes designed to assess, monitor and improve the quality and safety of services were not always operated effectively. Systems designed to assess, monitor and mitigate risks relating to health and safety and the welfare of people were not always effectively operated. Records were not always complete, accurate and stored securely. 17.

The enforcement action we took:

We served a notice that required the provider to follow an action plan to ensure improvements at the service were implemented.