Harborne Lane Specialist Care Centre Ltd

# Harborne Lane Specialist Centre

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

This inspection took place on 20 and 26 February 2018 and was unannounced. It was Harborne Lane Specialist Centre's first inspection since registration on 25 September 2017.

Harborne Lane Specialist Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Harborne Lane Specialist Centre is registered to accommodate 68 people in one adapted, four storey building. There are three independent units. The ground floor with 18 bedrooms to provide a service to people with complex nursing needs. The first and second floors both with 25 bedrooms on each, to provide a service to people primarily living with dementia. The home has a range of communal spaces including lounges, dining areas, quiet areas and a large landscaped garden. All the bedrooms are single occupancy with en-suite facilities. There were 39 people living at the home at the time of our inspection on the 20 February and this number had increased to 41 people on the 26 February. The home provides care and support to people from a range of ages, gender, ethnicity and physical abilities, including those living with dementia, learning disability and mental health difficulties.

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.

Systems in place to monitor and improve the quality of the service were not always effective in ensuring people received a good quality of service. Where there were audits, they had not identified the issues we found and had not always been consistently applied to ensure where shortfalls had been identified, they were investigated thoroughly and appropriate action plans put into place to reduce risk of reoccurrences.

Where risks were identified, we found that staff were not always provided with the relevant information in people's risk assessments to keep people safe. There were sufficient numbers of staff present to meet people's needs. However, we observed that where people required one to one support, as a part of their care plan, staff were not always able to provide this due to being busy elsewhere.

People's medicines were not always managed safely. We found shortfalls in the way that medicines were stored and monitored. Nursing staff did not consistently receive the clinical supervision that they needed and there was a lack of oversight from the provider.

Checks had been undertaken on new staff as well as agency staff to ensure they were suitable for their roles. Staff understood their roles in safeguarding people from abuse, but possible safeguarding issues had not been reported to the appropriate authorities. Where complaints or concerns were raised, the provider

responded to them. However, there was no analysis of complaints to identify and monitor for trends to reduce the risk of reoccurrences.

Although there was a contingency plan in place in the event of an emergency, we had identified some issues with the placement of some fire-fighting equipment. We made a referral to the fire service to review the fire procedures and equipment for the service.

Full information about CQC's regulatory response to issues and concerns found during inspections are added to this report after any representations and appeals have been concluded.

Where people lacked the mental capacity to make informed decisions about their care, it was not always clear how relatives, friends and relevant professionals were involved in best interest's decision making. Mental capacity assessments and best interests decisions were not always applied consistently to clearly show what decisions people were being supported or asked to make in relation to their care. Some applications had been submitted to deprive people of their liberty, in their best interests; however, we found applications were not always submitted in a timely manner.

Most people spoke positively about the choice of food available and people who were on food supplements received them. People were offered a choice of foods that reflected their dietary needs. We saw evidence that people were being supported to access healthcare professionals when required. Relatives told us the communication from the management team had improved at keeping them informed about their family member's care.

People received care and support from staff that had received training but their working practices and knowledge demonstrated that the training provided was not always effective and required improvement. Staff received supervision and appraisals and they felt supported to carry out their roles.

We saw staff treated people as individuals, offering them choices whenever they engaged with people. Where people had the capacity to make their own decisions, staff sought people's consent for care and treatment and ensured people were supported to make as many decisions as possible.

Some care plans contained person centred information, but we also found personal information was incorrect or missing in their care plans. This meant people did not always receive person-centred care. People told us that they often felt bored. We observed some activities taking place and saw evidence of some good practice in this area.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe

People were not always safeguarded from the risk of harm because possible safeguarding issues had not been reported to the appropriate authorities.

Risk assessments were not consistently completed which meant there was not always clear guidance for staff on how to safely care for people.

People were supported by sufficient numbers of staff; however at busier times of the day, staff were not always effectively deployed where they were required most.

People could not always be sure they were receiving their medicines effectively and the storage and monitoring of medicines required improvement.

People were protected from the risk of infection and cross contamination.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Although people had their needs and choices assessed, the initial admission assessments required improvement to provide staff with the information required to support people effectively.

People were supported by staff that had received training.

Risks associated with people's nutrition were not always managed effectively.

People had access to a range of healthcare professionals to support their needs.

Some people living with dementia were confused about their environment because the provider did not have effective dementia friendly signage and communication aids in place to support people.

We have made a recommendation that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'

Procedures were in place to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but these were not being consistently followed.

## Is the service caring?

**Requires Improvement**

The service was not consistently caring

Although people told us staff were caring, we found that the provider had not fully addressed risks that had been identified. This did not demonstrate a caring approach.

Staff that supported people were not consistent which meant people did not always receive care from staff that they knew well and felt comfortable with.

People were sometimes left in an undignified condition and staff did not always recognise these situations.

People told us their visitors were always made welcome.

People were supported with their independence, where possible.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People's care plans were not consistently reflective of their current needs, which placed people at risk of not having their needs met appropriately.

There were limited daily activities to support people's interests and hobbies.

People were aware of the complaints policy and how to raise any concerns they had.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led

Systems in place to monitor the quality of the service were not effective. There was no evidence of provider oversight of the service.

Some statutory notifications about notifiable incidents had not been submitted.

Most people were happy with the service they received from the provider.

# Harborne Lane Specialist Centre

**Detailed findings**

## Background to this inspection

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

The inspection was prompted following concerns received from partner agencies and members of the public that included but is not an exhaustive list:

-□Falls
-□Unsafe medicines management
-□Allegations of abuse

CQC was aware of safeguarding investigations and the injuries sustained by people living at the home. As a result of the number of concerns notified to us, over the short period of time since the home opened, we explored aspects of people's care and treatment during the inspection. This included reviewing current risks to people and the action taken by the provider to mitigate those risks. We examined the likelihood of any impact on people living at the home and whether the provider was in any breach of their legal requirements.

This inspection took place on the 20 and 26 February 2018 and was unannounced. On day one of the inspection, the team consisted of two inspectors, a pharmacist inspector, a specialist advisor and two experts by experience. The specialist advisor was a nursing practitioner with experience of working within a dementia setting. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of dementia care service. On day two of the inspection, the team consisted of two inspectors.

As part of the inspection process we looked at information we already held about the provider. Providers are

required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We checked if the provider had sent us notifications in order to plan the areas we wanted to focus on during our inspection. The provider had not submitted to us a Provider Information Return (PIR) before the inspection because the inspection was in response to concerns raised and a PIR request had not been sent to the provider. A PIR is a form that asks the provider to give key information about the home, what the service does well and improvements they plan to make. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority commissioners have concerns about the service they purchase on behalf of people. We also contacted the Clinical Commissioning Group for information they held about the service and reviewed the Healthwatch website, which provides information on health and social care providers. This helped us to plan the inspection.

We used a number of different methods to help us understand the experiences of people who lived at the home. We spoke with seven people, five relatives, two health care professionals, eleven staff members that included nursing, care, kitchen and domestic staff. We spoke with the registered manager, acting deputy manager and a trainer. We also spent time observing the daily life in the home including the care and support being delivered. As there were a number of people living at the home who could not tell us about their experience, we undertook a Short Observational Framework for Inspection (SOFI) observation. (SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.)

We looked at five people's care records to see how their care and treatment was planned and delivered and ten medication records to see how their medicine was managed. Other records looked at included three recruitment files to check suitable staff members were recruited. The provider's training records were looked at to check staff were appropriately trained and supported to deliver care that met people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Requires Improvement

# Is the service safe?

## Our findings

We had received a number of concerns and complaints from partner agencies and family members regarding the safety of people living at the home. We took into consideration the complaints and concerns when conducting this inspection and explored aspects of people's care and treatment. This included reviewing current risks to people and the action taken by the provider to mitigate those risks. We examined the likelihood of any impact on people living at the home and whether the provider was in any breach of their legal requirements. We asked people living at the home if they felt safe and reviewed the provider's processes and practices to safeguard people from risk of harm and abuse.

We had received concerns about medicine practice at the home. We looked at how medicines were managed, which included checking the medicine administration record (MAR) charts and associated records for ten people. We spoke with nursing staff and reviewed how medicines were stored. Our audit showed some discrepancies between the quantity of medicines found and the administration records, which indicated that some people had not received their medicines correctly. We audited some of those inhalers that had dose counters and comparing these with the administration records, it was discovered that these people were not receiving their correct dose. For example, the records showed that one inhaler containing 120 doses had been opened at the start of the current medicines cycle and the records showed that 30 doses were administered. We therefore expected to find 90 doses remaining in the inhaler however we found 115.

We found the medicines refrigerator temperatures were not being measured correctly to ensure the medicines stored would be effective. We found the provider was not measuring the maximum and minimum temperatures on a daily basis and therefore the provider was unable to demonstrate those medicines stored in the refrigerator were being stored safely. Readings taken on the day of the inspection showed the maximum refrigerator temperature was above the specified maximum temperature of eight degrees Celsius. We found that the refrigerator was storing temperature sensitive medicines called insulin. Not knowing whether the refrigerator had been maintained between two and eight degrees Celsius the provider was advised to obtain new supplies of the insulin and discard the current stock.

Some medicines that had been prescribed on a 'when required' basis did not have any written information to support staff on when and how these medicines should be administered. Where information was available to the staff in the form of a protocol we found the information was not detailed enough to ensure that the medicines were given in a timely and consistent way by the staff. For example, a 'when required' protocol informed staff to administer the medicines when the person concerned was 'agitated' or 'aggressive' but the protocol did not explain what the terms agitated or aggressive meant and how the person's behaviours might be presented. We found that where people needed to have their medicines administered directly into their stomach through a tube, the provider had not ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely. For example, no protocol was in place with information about how to individually prepare and administer each medicine. When we spoke with two nursing staff about administering these medicines, they were vague in their answers and only saying they were administered separately. One nurse said they used 15ml of water to

prepare each tablet the other said they used 30ml. The guidance available to nursing staff stated tablets that required crushing or were soluble, should be mixed with at least 30ml of water to ensure the tube would not become blocked. Using less than 30ml could increase the risk of blockages.

We looked at how Controlled Drugs were managed. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found that the Controlled Drugs were being stored securely but were not being regularly audited. As a result of this we discovered that one medicine had passed its expiry date, fortunately this medicine had not been administered to the person concerned following the date it had expired. We also found the ampoules of another Controlled Drug were all broken and therefore if the person concerned required urgent pain relief the provider would have not been able to meet this person's needs. We found the provider was not recording the location of where pain relief patches were being applied to people's bodies. We spoke with a member of the nursing staff who confirmed how the patches were being rotated around the body. We found the provider was not following the manufacturer's guidelines on rotating these patches around the body and therefore these patches were not being applied safely and could result in unnecessary side effects.

On the 20 February 2018, it was noted that the medicine trolley had been removed from its locked location and left by the main entrance to the lounge area on the first floor. The trolley was not secured to a wall and had been left unattended and unlocked by the nursing staff whilst they administered medicine to people. The registered and acting deputy managers were made aware of this. The registered manager told us this was not the nursing staff member's usual working practices and our presence had made them nervous. However, on the 26 February 2018 at 09.20, it was noted that the trolley was left again unattended and unsecured from the wall, by the lounge area door. Although, within an hour, the trolley had been removed and locked securely away in a storage area.

The administration and storage of medicines required improvement and meant this was a breach of Regulation 12 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Safe care and treatment. As a result of the concerns around medicine administration, we contacted the Clinical Commissioning Group responsible for funding nursing care at the home.

Shortly prior to this inspection visit, the police were leading an investigation into an allegation of abuse involving a person who used the service. The investigation was completed with no further action being taken. We discussed the incident with the registered and acting deputy managers and asked what improvements had been made to their processes to protect people from risk of harm. The registered manager acknowledged that the incident and the events afterwards could have been managed better. This included the failure to debrief staff and refer the matter to the local authority safeguarding team sooner. The registered manager had put these failures down to the actions of another manager and therefore no additional learning needs had been identified from this incident.

Most of the people we spoke with told us they did feel safe living at the home. One person said, "I feel safe. I haven't fallen down here." Another person told us, "The staff keep me safe." Most of the relatives we spoke with told us they believed their family members to be safe. One relative explained, "I definitely feel that [person's name] is safe. The staff know what they are doing." Another relative told us, "I feel [person's name] is very safe living here." Staff we spoke with recognised the signs of potential abuse and knew how and who to report any concerns to. One staff member said, "It is safe here but challenging. I see no staff rudeness or shouting at residents. Sometimes residents are agitated and swearing but I stay calm and talk to them." Another staff member told us, "If I saw anything that looked like someone was being hurt or abused, like bruising or a sudden change in their behaviour, I would tell the nurse or the senior." We checked the daily records and noted on five separate occasions there had been person on person contact. For example,

slapped, punched or hit with a walking stick/frame. We noted these incidents had not been reported to the local authority safeguarding team. We discussed these incidents with the registered manager and acting deputy manager. We were told the incidents had been dealt with appropriately by staff on duty at the time and because there had been no significant harm caused to anyone, the incidents were not thought to be reportable. However, the incidents were reportable and the provider had not recognised this.

We found on the days we visited the home, there were sufficient staff numbers on duty. The registered manager told us, they did not have a specific 'staff dependency tool' to help determine staffing numbers to ensure the staffing ratio to people living at the home met people's individual needs. However, the registered manager assured us if staff told them they needed additional numbers, the provider responded quickly and there was 'never an issue' with staffing numbers.

We noted on the 20 February 2018, there were two new admissions to the first floor. Both people were anxious, upset and one person walked around the floor in a confused state. We asked one of the nursing staff if staffing numbers would be reviewed in light of the increase in people. They told us they would 'ask the manager'. It became apparent at tea time, the deployment of staff required improvement or an increase in staffing numbers was required. A number of residents were shouting at each other, trying to remove shoes from other resident's feet, one resident had fallen and another resident had scratched their legs until they were bleeding. An inspector had to intervene on two occasions to seek assistance for two people. At the time of our second visit, we found additional staff had been brought in and the atmosphere of the home was less fraught. People we spoke with did not complain about staffing numbers and told us when they requested assistance; this was conducted in a timely way. One person told us, "When I press my call button, they [staff] do come quite quickly."

The feedback we received from people, relatives and health care professionals was more about the level of consistency for staff members. We saw the provider had a high number of agency staff working for them. The registered manager explained they used two agencies and the same staff would attend. This was confirmed when we spoke with some of the agency staff who had been at the home for a number of months. The registered manager also explained they were in the process of trying to recruit permanent nursing and care staff but this had proven to be difficult.

We checked three staff members' recruitment records and found the provider's recruitment practices required some improvement. Pre-employment checks were completed, including a Disclosure and Barring check (DBS) before staff started to work for the provider. However, where one applicant had gaps in their employment history, there was no evidence to demonstrate the provider had sought more information from the applicant. It is good practice for providers to ensure they explore employment gaps with prospective members of staff. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people. We also noted on one of the records that a second reference had not been sought and another reference had been left unsigned and undated with no evidence it had been checked for authenticity. We discussed these issues with the registered manager who said they would review the recruitment files.

We checked the fire exits were clear and fire extinguishers were available on all floors of the home. We noted on the ground and first floors the fire extinguishers had been removed from the walls and relocated into the stairwells. This meant the metal brackets that secured the fire extinguishers to the walls were left exposed and presented a risk of harm to people. As the home had a number of people living with dementia they may not be aware of the harm that could be caused from protruding metal brackets. We raised these concerns with the registered manager at the time of the inspection visit. They told us the extinguishers had been removed because 'some people' had kept removing them from the walls and 'throwing' them to the floor.

We also noted the fire extinguishers relocated to the stairwells were not secured or standing on a designated fire safety platform. On the first floor stairwell, two extinguishers were placed at the foot of the flight of stairs and slightly to the right which posed a potential trip hazard for anyone coming down or up the stairs. On the third floor, it was noted in one of the laundry storage areas that a smoke detector had not had its protective cover removed. As a result of these findings, a referral was made to the fire service to request a check on the home's environment.

We found that risk assessments did not always clearly set out how to meet people's individual care and support needs and keep them safe. At this inspection, we found some risk assessments remained incomplete and in some instances, had not been completed. For example, one epilepsy care plan we looked at, there was no information about the person's individual triggers, types of epilepsy, nor the signs and symptoms to be vigilant for in the event of a seizure occurring. The plan said, "If [person name] has an epileptic seizure staff must ensure their safety, time duration of seizure and if seizures are prolonged to have PRN medication if this does not control seizures paramedics need to be called'. There were no other details provided as to how long the seizures should be timed for, how a seizure would present itself and how to keep the person safe during the seizure. Nursing staff we spoke with were unable to be more specific about managing an epileptic seizure for this person and told us they had not had any seizures for some time. We could not be assured that staff knew how to keep the person with this condition safe.

Where people were at risk of developing sore skin, this was set out in their care plans. One care plan we looked at, a nursing staff member told us the person required two hourly repositioning. We had seen on the first day of our inspection visit, the person was seated in the same position for four hours. Although they did have protective cushioning around their feet, we noted the feet were not placed on the foot rest of the reclining chair, but left unsupported hanging over the edge. This meant there was a risk of swelling to the person's ankles and feet that could have an effect on the integrity of their skin. We asked to see the daily wound plan for the person. The nursing staff tried to locate this but it could not be found. Although they told us the sore skin had improved from when it was first noticed, there was nothing recorded in the daily notes or care plan to confirm this.

We looked at the cleanliness and hygiene of the home. Although the provider told us audits had been completed around infection control, we found the audits were not completed and there was no effective process in place to review the outcomes of the audits to enable appropriate action to be taken if and where appropriate. However, no concerns were raised with us about the upkeep and cleanliness of the home. One staff member told us, "This is a lovely and clean home." We completed a visual check of the environment. We found that the day to day cleaning of the home was adequate. Gloves were available for staff to use when providing care. We had noted there was a spillage on the first floor but this was cleaned up quickly by domestic staff. We looked at the laundry area and found it was organised. We also observed the kitchen area was clean and suitable to prepare food.

Requires Improvement

# Is the service effective?

## Our findings

Some of the people we spoke with told us they had been involved in the assessment of their care and support needs. One person explained, "I do recall the manager coming out to talk to me before I came here." A relative told us, "[Person's name] was recently assessed as there has been a change in their health and they can no longer eat without support, they [the person] now requires a soft diet." We looked at five care files and saw evidence to support that elements were individualised for people. We looked at how two people's needs and choices were assessed at the point of admission to the home. We noted that the initial admission information was incomplete or missing. It was also difficult to locate any base line measurements for people. For example, their weight and vital readings such has blood pressure. No body maps were completed. (A body map shows injuries, lesions or wounds on a person that could be used to record an allegation of mistreatment). This was important because one person was admitted with scratch wounds to their legs and the second person had a history of falling and may have had old scaring or marks on their body. We discussed with the nursing staff the importance of completing a body map on admission so the nursing staff could account for any injuries, marks or bruising found on people. One staff member told us there was not always enough time to complete the admission forms and care plans when new people arrived to the home. The registered and acting deputy manager started to review care plans and assessments for people living at the home in response to the issues we had identified. When we returned on the second day of our visit, some of the information had been completed. The acting deputy manager explained they had started to address the gaps in the information and there was further work to be completed but gave us their assurances this would be accomplished in a timely way.

We had received concerns that people that required support to eat did not always receive it. A relative told us, "A few weeks ago the lunchtime meal had been left on the bedside table but as my relative cannot sit up they were unable to feed themselves - it was just left there and had gone cold." We conducted an observation of lunch time on the 20 February 2018 and found one person that required one to one support was left unattended for 20 minutes during their meal. We saw the person play with their food but did not attempt to eat it. A staff member did eventually sit with the person and tried to encourage them to eat what would have been a cold dinner. The person ate some of it but then refused the rest. The staff member had not offered to warm the dinner up or get a replacement meal. We saw another person refuse their lunch which was immediately taken away by the staff member with no encouragement for the person to try the meal or an alternative meal offered. At our visit on 26 February 2018, we saw the person who was receiving one to one support to eat had been relocated to another floor and was being supported to eat their meal and they appeared to be enjoying the food. The staff member was positive with their encouragement and the person ate most of their meal. We discussed the concerns raised with us by family members and our observations with the registered manager; they told us people were supported by staff members to eat and meals were not left. This had not been our observations at the time of the first inspection site visit; although there had been an improvement at our second visit.

There were mixed responses from people about the quality of the food. Comments included, "The food is excellent with plenty of choices". "I don't like the food here, I tolerate it." "The food here on the whole is very good. I am not on any special diet and get plenty of variety and food to eat." "I get plenty of food, it's

nice." "The food is awful," and "You get two choices and porridge and eggs in the morning. There is plenty to eat though and you can get a snack if you want." We saw that people could choose where they wanted to eat with some choosing to remain in their rooms or the lounge areas. Staff respected the people's wishes. The kitchen staff told us if someone did not like the food they were offered or had changed their mind, they prepared a different meal choice for them. The kitchen staff also explained care staff would let them know people's choices and which people required special diets and they showed us how this information was relayed to them. Kitchen staff explained how they would add additional calories to food for those people at risk of losing weight. Where appropriate, we saw referrals had been made to appropriate professionals for people that were at risk of choking or losing weight. For example, to the Speech and Language Therapist (SALT) or GP.

We reviewed the menu available for people and noted meals were culturally appropriate and prepared by kitchen staff on site at the home.

People told us they felt supported by suitably trained staff. One person said, "Staff are well trained. They [staff] do a bit more for you. The nurses are all qualified. They are all professional here. New staff are here and they get training too." Another person told us, "Staff are skilful." Staff did not complete the Care Certificate but told us they had completed training that reflected the Care Certificate standards. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. The registered manager explained, "There's a two day induction which includes all the basic information. New care workers are given tests to check understanding after training. We train people above and beyond what is needed. Everybody is trained before they come in. New care workers will start by shadowing experienced care workers, if something comes up requiring further training, that training will be supplied." Staff we spoke with felt supported by the management team and were satisfied with the level of training they had received from the provider. Comments from staff included, "My induction was good. I completed all the mandatory training in fire, manual handling, nutrition and the mental capacity act." "The induction gave me the information I needed," and "We have good training, the trainer is a nurse who works on the floor so can tailor training to individual people."

Staff we spoke with confirmed they had received supervision from a member of the management team and told us they felt supported. One staff member said, "The managers are very good, very comfortable to approach and they spend time on the floor." This was confirmed by the other staff we spoke with. People had been supported with their health care and support needs and records we looked at demonstrated that people had access to local health care services. For example, the GP, dentist, the optician, podiatrist and psychiatrist. Staff spoken with explained how they supported people with the healthcare needs. One staff member said, "It's important we read people's care plans so we know what we need to do for them." We saw from reviewing people care plans that health care professionals visited regularly, one person told us, "The doctor comes in every week". During our inspection site visits, we saw a number of different health and social care professionals visit people to assess their health and wellbeing. One person told us, "I can get a doctor easily. The home will call one for me. I am going to see a dentist. I have seen an optician recently." Another person said, "If I am ill the staff come quickly to get me any medical help."

On the 20 February 2018, we walked around the home to assess the environment for people living with dementia. The registered manager had explained to us that the second floor was not yet completed and there were no people living on this floor, however on the 26 February 2018, we found there were three people living there. We found the home lacked facilities for people living with dementia. There was limited dementia friendly signage, all the bedroom doors were the same colour as the communal bathrooms and we saw a number of people trying different doors looking for their own room or the bathroom. We saw

scribbled notes were left on some doors describing them as the bathroom or the name of a person's bedroom. One person approached us distressed that they could not find a bathroom. There were some bedroom doors that had been personalised by the person or their family members but a majority of doors had not and were identical. The environment was similar to a hospital as opposed to providing a more homely environment. There was limited stimulation for people living with dementia, for example very little for people to touch or feel. We discussed the lack of a dementia friendly environment with the registered manager who agreed this could be improved upon.

We recommend that the service explores the relevant guidance on how to make environments used by people living with dementia more 'dementia friendly'

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw staff did seek people's consent before completing certain tasks and offered people choices. For example, choice of drinks at different times of the day. Where people were deemed to lack the mental capacity to consent to some of their treatment or care, we found mental capacity assessments were not always decision based and were generic. Some decisions had been taken without following a best interests process, made by family members who did not have a legal power to do so. For example, we found that where people needed to have their medicines administered, without their knowledge, by disguising them in food or drink. We found there was no evidence that a multidisciplinary team had discussed the administration problem and had made a decision based of that person's best interests.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. There were a number of people that had been deemed to lack the mental capacity to consent to their being at the home or their care and treatment and no applications to lawfully restrict them from leaving had been submitted to the supervisory body. The MCA DoLS require providers to submit applications to a supervisory body for authority to do so. However, on our second visit, the management team had started to take immediate action and provided us with evidence to demonstrate that applications had now been submitted to the supervisory body, or were in the process of being completed.

Requires Improvement

# Is the service caring?

## Our findings

People we spoke with thought staff were caring. One person said, "I need a lot of help. The staff are very patient and kind." Another person told us, "My spouse came to look at this home. I did not think that I would like living here but I do and I am very happy here. I don't think that you will find a better home. I have a beautiful room – plenty of room for one person. The staff are absolutely fantastic, can't do enough for you." A relative we spoke with told us, "The staff are very friendly and very good. They [staff] are caring and talk to my relative when they are attending to their needs." We saw staff were patient with people and polite with some positive interactions with people. For example, one staff member was supporting a person, who was extremely anxious, to walk around. The staff member spoke kindly to the person, offering lots of reassurance and encouragement. We also observed staff were very busy, with limited time to sit and talk with people, this led to staff missing opportunities to interact with people more. For example, we saw staff supporting one person with their meal; the staff member did not sit next to the person but stood up to the person's right side. The staff member only sat down when advised to by another staff member. While some individual staff were seen to be kind and caring, the provider's systems and processes did not always mean people experienced caring care.

People we spoke with told us staff respected their privacy and dignity. One person told us, "The staff are very respectful." Staff addressed people by their preferred names and we saw staff knock on bedrooms doors and call out to the person before they entered. One person had requested a key to their door and chose to lock it at night. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity. However, on the first floor on the 20 February 2018, we saw one person was left in the main lounge area with sore legs that were bleeding and we had to intervene and ask for a staff member to dress the person's legs. We also noted a second person that was confused, was walking around the floor in a state of undress. Both people were new admissions to the home that day. We had not seen any staff member sit with them to provide reassurance. When we discussed our observations with the registered manager, they told us staff would spend time with new arrivals but that the inspection had impacted on this. Our own observations showed that at the time of our first inspection visit, consideration had not been given to staffing numbers or their deployment to account for the individual needs of the two new admissions. When we returned on 26 February 2018, the staffing levels had been increased appropriately.

People we spoke with told us they were involved in decisions about their care and support needs. One person said, "I talk about my care with my carers and they listen." Another person told us, "Staff ask me when I want to go to bed. Everything is done very well." One staff member told us, "I ask people where they want to sit and if I am giving an intimate service to people I ask them what makes them comfortable." We had received some concerns that people's cultural dietary requirements were not always catered for. We discussed meeting people's dietary needs with the kitchen staff. They showed us culturally specific food that was stored independently from other foods and we saw the menu reflected people's cultural and individual needs.

Staff were able to explain to us how they encouraged people's independence and supported people who

could not always express their wishes. For example, staff said once they got to know people, they could tell by facial expressions and body language, whether the person was comfortable with the level of care being provided. If the person was showing any signs of distress or anxiety when care was being provided, staff told us they would find alternative ways to deliver the care and provide lots of reassurances until the person was more relaxed. For example, we saw one staff member asked a person if they had finished with their empty plate and if they could take it away. The person became anxious and held onto the plate and told the staff member to leave them alone. The staff member smiled at the person and replied in a soft tone of voice they would come back later. We saw that staff were friendly in their approach to people and they laughed with people. People who were independently mobile had their with walking frames close to hand and those spoken with considered themselves to be able to be independent for getting up and doing as much as possible for themselves. We saw five residents on the first floor come and go to the lounge and their rooms as they wished.

Everyone we spoke with told us there were no restrictions when visiting. A relative told us "I visit at different times." We found people living at the home were supported to maintain contact with family and friends close to them. Staff we spoke with was aware of the individual wishes of people living at the home that related to their culture and faith. One person told us, "I'm not a religious person but I have seen members of a church visit people who do have religious needs." People could be confident their individual preferences and choices relating to their culture, faith and gender would be respected by staff.

Requires Improvement

# Is the service responsive?

## Our findings

People and relatives we spoke with explained how they were involved with the planning of their family member's care and support needs. One person said, "The staff do ask me how I like things to be done." A staff member we spoke with said, "I have seen people's care plans whose assessment shows their level of ability, interests and ways to communicate. I use that information to engage that person." Although we could see some care plans had been reviewed, there was no evidence to show how people or their family members had been involved in the review process. For example, on one file, a consent form for the use of bed rails, had been signed by a staff member, there was no signature from the person or the person's representative. There were care plans more detailed than others with some containing only a small amount of personal life history in them. We were told by the registered manager that due to staff members being away ill, this had led to a delay in reviewing the care plans and steps were being taken to rectify this. Staff we spoke with were knowledgeable about the needs of people who had been resident at the home for a period of time. For one person we noted their file contained a blank 'This is me', no admission assessment, a form titled 'Care Plan involvement' was blank and the 'family communication form' was also blank. On speaking with staff they told us the person required their fluids to be thickened so they could swallow their drink safely, but this had not been recorded in their care plan. Although staff we spoke with knew the amount of thickener to add to the person's drinks, because this was not recorded and as there was a high dependency on agency staff, this could have the potential to put the person at risk of choking. The registered manager explained, "We only use two care agencies. The staff they send us have worked at our other locations before, it is rare that they send people that we have not worked with."

One person received their nutritional intake through a nasogastric tube (tube inserted through the nose). We saw this had been repeatedly referred to as a PEG in their care plan. A PEG is a completely different form of nutritional intake (tube inserted directly into the stomach). There was a second person that did receive their nutritional intake through a PEG and they were also cared for in bed. On checking their care plan we noted there was conflicting information as to how the person should be transferred. It was suggested that a sling could be used and elsewhere in the care plan it suggested that it should not be used. On speaking with staff they told us they did not transfer the person as they preferred to remain in bed. However if the person had wanted to get up the information on how to do this safely was unclear. Because some of the care plans were incomplete it would be difficult for agency or new staff in particular, to know exactly what peoples' individual care needs were.

We did see some good practice when staff responded to two people's needs. A staff member required additional assistance with a particular procedure. We saw the staff member followed the protocol and was able to get the assistance they needed promptly. We also saw one staff member use a board to communicate with a person about their choice of drink. The person chose a cup of coffee.

All the staff we spoke with told us that they received updates about changes in people's needs, in handovers between staff at shift changes and would also read people's care plans. One staff member explained, "If you're unsure of anything you would read the person's care plan or ask the nurses or managers."

We received mixed responses from people we spoke with about the provision of activities. One person said, "I read, play games, do activities. I go to the local when I have company." Another person told us, "I haven't done anything. Only sitting and talking. They [staff] never ask me what I am interested in." A staff member explained, "We have mobility exercises. They [people living in the home] had singing and bingo on Sunday. But I'm not sure about one to one activities with people in their bedrooms." A social care professional told us the person they supported liked to dance to music and had suggested 'doll therapy' for them, but could not be sure if this had been provided. They continued to tell us they had not seen much activity for any of the people living at the home. The home employed two staff to co-ordinate activities, hobbies and interests. One staff member was part-time at one day per week. We did see on 20 February, a visitor came onto the ground floor lounge area to do seated yoga. We saw they encouraged five people to form a circle. This was a regular event and the visitor knew the people's names. During the session people responded to the visitor's instructions and appeared to be enjoying the exercise. However, we could not see evidence of any person centred hobbies or activities suitable for people living with dementia taking place. We discussed our observations and feedback with the registered and acting deputy managers. The registered manager told us they had only recently employed the activities co-ordinators, who had only been in post for approximately four weeks and they were still in the process of putting together a comprehensive programme. We noted the home had been open since October 2017, was purpose built, with a specialism in providing a service for people living with dementia. We found there were no visual aids or tactile objects. For example, books, toys or age related memorabilia. Such items can act as prompts or memory triggers for people living with dementia and enhance their mental wellbeing.

The lack of regular and consistent activities for people and lack of consistent person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014).

There were mixed responses on how the service dealt with complaints. We had received concerns from family members; they told us when a complaint had been raised the response from the management could be better. For example, keeping the complainants up to date during the complaints process. At the time of the inspection site visit, most of the people we spoke with and most of their relatives told us they were satisfied with the provider's complaints process. One person told us, "I made a complaint about hygiene issues to the manager and it was sorted out." Other comments included, "If I wanted to complain I would talk to the one in charge," and "I am confident that If I had any complaints I would voice them to the staff." A relative said, "On one occasion they [staff] put two lots of pads on which caused my relative discomfort all night. This did take a few weeks to sort out but it does appear to be working ok now." A social care professional explained how pleased they were that the concerns they had raised about the service's response to the person they were supporting had improved from their last visit. We reviewed the complaints file and could not see any complaints recorded. This was not reflected in the conversations we had with some of the relatives or the issues that had been notified to us. The registered manager explained they had dealt with the issues and they had been resolved quickly. However, we could not see how the provider had monitored the concerns for trends to ensure the service could be improved upon and reduce the risk of any reoccurrences.

Requires Improvement

# Is the service well-led?

## Our findings

When reviewing the provider's governance systems, we considered that the home had been operational for less than six months. We had also taken into account the difficulties the provider has had with staff retention and long term sickness. The provider and registered manager operated another two established homes. Therefore, it was reasonable to anticipate that systems in place to monitor the quality and safety of the service would be effective. One of the provider's operational support managers was absent for a period of time and the home's registered manager told us this had contributed to the delay in reviewing and completing care plans, risk assessments and quality audits. To help address these issues and ensure all records were brought up to date, the provider had appointed an acting deputy manager. At the time of our first visit, the acting deputy manager had only been in post for two days. We found the provider's systems to monitor the quality and safety of the service, had not always been used effectively to implement or sustain improvements, where shortfalls had been identified. This was evident for some of the shortfalls we found during this inspection. The provider's systems to monitor accidents and incidents for themes and trends in order to mitigate the risk of any reoccurrence, required improvement. The provider's systems in place to evaluate staff knowledge on completion of some of their training required improvement. For example, the effectiveness of DoLS training to ensure staff knew how to ensure people's legal rights were been promoted. Systems were not in place to effectively record the amounts of fluid and food intake for people at risk of weight loss. The provider's 'slips, trips and falls' policy stated people were to be encouraged to wear shoes with non-slip soles. Nonetheless, we saw one person had spent the entire second day of our inspection visit with one slipper on their left foot and just a plain sock on their right foot even though the person had been identified as high risk of falling.

We found initial admission records, risk assessments and care plans had not been consistently and accurately completed and on occasion had contained incorrect or missing information about people. Recording errors meant that the medicine administration records were not always able to demonstrate that people were receiving their medicines as they should. For example, we found staff initials were missing from some administration records so we were unable to establish if the medicines had been administered. The receipt of medicines was not always being recorded, the provider was not always taking into account the transfer of medicines from one medication cycle to the next and where medicines had been refused the disposal of these medicines was not being recorded. Information relating to peoples' care and support needs was spread across three or more files making information difficult to locate, duplication and contributed to information being incorrect or missing. It was difficult to identify if flushes were being carried out between PEG feeds because entries were not always recorded or identified on the person's fluid records, although nursing staff told us they did ensure PEG tubes were flushed between feeds.

The lack of robust quality assurance, information missing from records and the inconsistent leadership and governance at the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). Good governance.

The provider had failed to inform us of a number of safeguarding incidents they were required to by law. There had also been a number of injuries sustained by people at the home which resulted in people being

taken to hospital that we had not been notified of or the notification was not made in a timely way. The provider had a legal responsibility to ensure these significant events were notified to the CQC.

This was a breach of Regulation 18(1) Notification of other incidents, Care Quality Commission (Registration) Regulations 2009.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The registered manager was able to tell us their understanding of this regulation and we saw some evidence of how they reflected this within their practice. However, where issues had been found, the registered manager deflected responsibility for those failings onto other members of staff. We reminded the registered manager that responsibility for managing and maintaining the home was ultimately their responsibility. The registered manager was not overly receptive to our feedback and explained to us they felt the inspection had been negative and critical. We explained to the registered manager that due to the number of concerns that had been notified to us from professionals and family members, we had a duty of care to look into those matters in more detail and report on our findings.

At the time of our inspection the service had not held any 'residents or relatives meetings.' We saw dates had been set for meetings during 2018. The registered manager confirmed that due to low numbers of people living at the service the meetings had not taken place before the start of this year. As an alternative the relatives or representatives of the 26 residents living at the service in January 2018 had been sent letters inviting them to an annual care file review, which offered the opportunity to express any concern or preferences for the care of their family member. The registered manager told us to further help communication with staff they were introducing 'flash meetings' each day with the heads of departments to have a 'quick discussion' about daily needs in the home.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and there was a whistle-blowing policy in place. They continued to explain the management team were approachable and if they had concerns regarding the service and they would speak with them. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. The whistle-blowing policy supports people to raise their concern(s) within the organisation without fear of reprisal or to external agencies, such as CQC if they do not feel confident that the management structure within their organisation will deal with their concern properly.

Most of the people and relatives we spoke with were positive about the management of the home. When we asked people and relatives if they felt anything could be done to improve the service, one person told us, "Not at the moment. I know the home is a bit upside down because it's being refurbished, but we could have more fruit and better food." A relative said, "The home needs regular staff and more activities for people." Other comments included, "I am very happy here, I have a lovely room and the staff look after me very well." Staff we spoke with told us they had staff meetings and gave us examples of suggestions they put forward and adopted by the provider. For example, moving the photocopier for weekend access and the introduction of a 'red book' for comments and suggestions. Staff we spoke with commented, "I am very happy here and wouldn't change a thing," "The managers are very good," and "The best bit about working here is the management, they're good. We are getting better working as a team and we are all settling in."

We saw evidence to support the service had worked in partnership with other organisations, stakeholders and healthcare professionals. We had received feedback stating that initially communication was poor from

the service but this had improved over the last two months.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to inform us of a number of safeguarding incidents they were required to by law. There had also been a number of injuries sustained by people at the home which resulted in people being taken to hospital that we had not been notified of or the notification was not made in a timely way. The provider had a legal responsibility to ensure these significant events were notified to the CQC.<br><br>This was a breach of Regulation 18(1) Notification of other incidents, Care Quality Commission (Registration) Regulations 2009. |

**The enforcement action we took:**

Considering issuing a fixed penalty notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The lack of regular and consistent activities for people and lack of consistent person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014). |

**The enforcement action we took:**

Imposed a positive condition

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The administration and storage of medicines required improvement and meant this was a breach of Regulation 12 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Safe care and treatment. |

**The enforcement action we took:**

Imposed a positive condition

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The lack of robust quality assurance, information missing from records and the inconsistent leadership and governance at the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). Good governance. |

**The enforcement action we took:**

Imposed a positive condition