Golden Age Management Limited

Attwood's Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this focused inspection on the 11 May 2016. This unannounced focused inspection was carried out to check that the provider had made improvements required following our previous inspections in December 2015 and November 2015.

This inspection was also to follow up a number of concerns we had received about the safety and standards of care people were receiving. Information of concern we received related to people allegedly not receiving their medicines as prescribed, staff shortages particularly at the weekends and people not always receiving their care in a timely way. We followed up at this inspection two significant events that the provider had failed to tell us about at the time as is required by law. The events could have resulted in significant harm to people. We only looked at the Safe key question during this inspection.

The service is registered for 65 people. 54 people were living at the service on the day of our inspection. The service has a registered manager. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However the registered manager has had a period of extended leave and was not at the service during the most recent inspections to the service. An acting manager was in post.
We carried out a focussed inspection of this service in in November 2015 and found that the provider was not meeting the requirements of the law as they did not protect people against the risk of receiving care or treatment that was inappropriate or unsafe. We judged the service to be inadequate. Following this inspection we placed a number of conditions on the provider's registration using our urgent enforcement powers. The first was to prevent them admitting anyone else to the service until they had made the necessary improvements. The other condition imposed stated they must always have competent staff to administer medication as during our inspection in November 2015 we found practices around medication administration were unsafe. We carried out a further inspection to this service in December 2015 and found that improvements to the administration of medicines had been implemented, however the service was failing to meet the requirements in all other areas inspected and required improvement. During this most recent inspection in May 2016 we found some improvements in the management of people's medicines. However, we remained concerned as to the quality of the care provided. The condition on the provider's registration preventing further admissions to the service was lifted in January 2016.

During this inspection on the 11 May 2016 we carried out a very detailed medication audit and found that staff administering medication were knowledgeable and competent to do so. A number of minor issues were identified for the provider to address and we have issued a requirement notice as we were not assured that people always receive their medicines as intended.

There were enough staff to deliver safe, effective care on the day of inspection. However staff, relatives and people using the service told us this was not always the case and staff shortages recently had led to

compromised care at times.

Risks to people were managed but the service was not always proactive in assessing the risk, therefore we were concerned that people may have experienced unsafe care because insufficient actions to mitigate the risks had been taken to ensure their needs were being met safely.

Staff understood their job roles and were able to undertake tasks and report any concerns they might have about the care and welfare of people using the service. However, we identified three staff with a poor grasp of English. They were not able to demonstrate sufficient understanding of how to keep people safe. In addition we found poor involvement and consultation with people and their families about the service provided and how improvements could be made as a result of people's experiences. Some people and families raised concerns with us which had not already been raised with the service. The service was not sufficiently proactive in identifying how people were and how their care was being managed.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We have also made a recommendation about what information should be available for new or temporary staff.

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 is not always safe.

There were not always enough staff sufficiently familiar with people's needs to deliver safe and effective care.

Risks to people's safety were not always well managed.

Staff were aware of how to safeguard people from the risk of abuse and how to raise a concern if they suspected a person to be at risk of harm or actual abuse. However, not all staff had the necessary competencies and understanding.

There were systems in place to ensure people received their medicines safely and by staff who were trained to do so. However, people did not always receive their medicines as required and prescribed.

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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 took place on the 11 May 2015 and was unannounced. The inspection was carried out by two inspectors, one who was a pharmacy inspector. There was also 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. Our expert by experience had expertise in older people.

Before the inspection we looked at the information we already held about the service including statutory notifications. These are important events affecting the safety and, or well-being of people using the service. We looked at previous inspection reports and spoke with a number of people who had raised concerns with us about the service which led us to re-inspect the service.

During our inspection we carried out observations in each part of the service. We observed meal times, medication administration and the care provided to people. We spoke with five visitors, nine staff and eight people using the service. We looked at a number of records relating to the management of the service and requested some additional information following our inspection.

Requires Improvement

Is the service safe?

Our findings

On the day of our inspection there were enough staff to meet people's needs. There were eight staff, one of whom was new and working under supervision. The acting manager and activities coordinator were also on duty. We saw that people mostly received timely care and call bells were answered promptly.

However, there had been a number of changes within the service including a number of long standing staff leaving and being replaced by new staff. Recruitment was ongoing for new staff but the acting manager was unaware of the number of vacant staffing hours the service has. The provider does not have a bank of staff who could pick up casual hours but were using regular, occasional agency staff to cover vacant shifts. These staff were not as familiar with people's needs.

We received mixed feedback about staffing levels. Staff spoken with said they sometimes worked with less staff than they needed to meet people's needs. This was evidenced by the four week rota we viewed which showed fluctuating staffing numbers. The acting manager told us staff recruitment had improved and staff told us that the provider had listened to their concerns and had employed regular agency staff to ensure people's needs were met and were themselves often at the service and able to monitor the level of care provided.

One relative told us, "General care is pretty good but the biggest downfall is the agency staff and the new staff." They told us new staff were not sufficiently familiar with their relatives needs and important things were missed. They told us they had raised this with the service but nothing had improved. In addition we received concerns from relatives before and after the inspection of how the service had fallen short of their expectations. We asked the acting manager about the induction and support of new and agency carers. It was clear that new staff were adequately supervised whereas agency staff were expected to be supported by a senior member of staff. However when we asked the manager they were not able to show an initial induction completed for agency staff so we could not be assured they were supported sufficiently.

We recommend that the service develop a one page profile for people which could be used by new staff and agency staff to help them know what people's needs were and how they should support them.

Another relative told us that it was, "Chaotic last Saturday morning, lots of agency staff." We looked at the rotas for that day and saw that there were six staff scheduled to work, three were experienced staff, one was agency staff and two were new staff. Staffing levels according to the rota reduced to five in the afternoon. This was in comparison to the numbers on duty in the week which exceeded eight staff. This meant staffing levels were reduced by up to 50% at the weekend. Another relative told us that the previous Saturday they had to wait for staff to answer the front door bell for a considerable period of time and others were waiting too.

Staff told us, "Safe, yes but we still need more staff especially in the morning." Another staff member said, "You know when it is desperately short sometimes it is right and yesterday was alright but last Thursday was desperately short only four staff." (Half of what is required.)They said this meant they were busy, on the go

the whole time. We asked staff if people always got the care they needed when the service was so short of staff and were told, "Yes but not enough staff or time to do the task we are reactionary and we have to prioritise situations." They also said people in their rooms might get forgotten unless they use their buzzers. We were unable to establish how many people were not actually able to do this and given the layout of the building could be waiting some time for staff to attend to them. One person told us, "At 9.45am staff came in and told me they would be back and came back at 10.50am to bath and dress me." Another person was supported at 10.30 am with their personal care and was the last to be assisted up on the ground floor. The first thing they said was "I am so thirsty."

One person told us, "Not enough staff – definitely not." They told us staff "leave you at the tables and you have to wait until someone happens to walk by before you can move from the tables"

Throughout our observation we saw that staff were attentive to people but there were times throughout the day when communal areas had no staff present. Relatives confirmed this was sometimes the case. For example at 10.10am 28 people were in lounges with no visible care staff. This was a risk due to the frailty and the distressed behaviours some people displayed which could put themselves or others at risk. The acting manager said staff should always be present in these areas but there was no evidence to show this always happened in practice. In the communal areas there was no means for people to call for assistance. No call bells were in place and no one had pendant alarms. This meant people were not able to make their needs known and could be placed at risk by others behaviours. One person told us they sometimes went out of the service but when trying to get in had to shout as no one answered the door.

Most people using the service were encouraged to come into the communal areas for their meals and to join in social activities. We noted most people were up at the time of our inspection shortly after nine a/m and when we asked staff they told us only two people on the ground floor were still to get up. Staff told us by eight a/m 30-32 people were already up and dressed by night staff. We were unable to establish if it was people's choice to get up so early or if people were being awoken early. We spoke with relatives, one told us, "She looks uncared for today no glasses on they get them all up for breakfast they must be rushed and I ask what time do they start in the mornings getting them up?" We asked the acting manager to review this to ensure people were being supported in the way they wished to be.

The service provided a range of social activities for people and had two staff whose responsibility it was to provide activities for up to 30 hours a week. Despite planned activities we observed lots of people disengaged with limited opportunity to take part in activity which were appropriate, or suitable for their needs. One person told us the," Activities were boring." Another person said they could not converse with other people using the service as most had dementia. A relative told us their family member had been isolated at the service due to most people having some form of cognitive impairment so they had no one to talk to. We noted lots of people not partaking in activities for example one person was slumped in their wheelchair the whole morning from just after 9.00 am with their head down on their chest. When we asked staff about them one went to her and said, "Would you like to come into lunch or would you like a snooze." There was no encouragement given to them to socialise or to eat.

The number of specific hours set aside for the provision of activity was not proportionate to the numbers of people using the service had. We saw some meaningful engagement with staff and people using the service which enhanced people's well-being but staff were busy throughout the morning and staff said time with people could be compromised when they were short of staff.

The acting manager told us the dependency tool used by the service to ascertain how many staffing hours they needed to meet people's needs had not recently been updated or in fact was not the right tool for the

service and this was being looked at. The service had grown in occupancy since our last inspection and staffing levels had increased. However, without a clear analysis of the dependency levels of people using the service it was difficult to establish if there were enough staff. The service was not notifying us as required by law when the staffing levels dropped and could result in compromised care.

Before the inspection concerns were raised about people not always receiving care in a timely way because staff were busy such as assisting people with their personal care needs. We did not see evidence of this during our inspection but one person told us they had witnessed staff not responding to people in a timely way despite them calling out for staff to support them. People told us they had personally been told they could not go back to their room when asked because staff were too busy attending to others. A number of relatives told us care was not always provided as required.

We were not confident that all the staff had the necessary skills and competencies to meet the needs of people using the service .Three staff had a poor command of English and needed to rely on other to support them with their communication skills. This meant that people using the service were sometimes supported by staff who might not understand their needs or be able to respond appropriately to any given situation/emergency. A person using the service told us some staff could not understand them. Another told us, "Not too bad here, they, (the staff) are quite kind." They have lots of new ones, lots of agency not keen on half of them they don't know what they are doing. I have cream on my back and legs and I have to tell them what to do." They said, "Some staff I don't care for it is difficult and you have to do the best you can with them."

The deputy manager was taking a lead on staff training and showed us that staff training was mostly up to date and they had been able to access more training to help enhance the skills of the work force. Some staff had also completed enhanced training around dementia care. None of the care staff had completed training in mental health or had necessary information about long term health care conditions some people had. There were and had been people using the service with mental health issues and it is important staff know how to monitor people's well being and ill being.

The above demonstrates a breach in Regulation 18 (regulated activities regulations) Staffing.

Staff spoken with had access to information about how to safeguard people in their care and there was information around the service to help relatives know how to raise concerns. Staff had received training however due to poor language skills in some instances we were not confident that all staff would know when or how to raise concerns. Several relatives told us they did not feel all staff were very approachable and some felt they had to raise concerns more than once. We saw the service took into account events affecting the well-being and safety of people and had notified the Local Authority. We viewed a number of safeguarding's which had been raised in recent months some of which had been substantiated so we have asked the service for additional information about these and what has been put in place to reduce further incidents.

During our inspection we asked for additional information with regards to a number of specific incidents where people potentially were at risk of harm. The provider had failed to notify us of these incidents at the time which meant we were not able to respond accordingly. The provider had ensured appropriate actions were taken to support people within the service and address the concerns. However a copy of the investigation into the circumstances leading to events which could have compromised people's safety were not available and we had not been appropriately notified of the events as required by the registration regulations.

This is a breach of Regulation 18: Notification of other incidents (Registration) Regulations

At our inspection we identified a number of people with bruises, and looked at accident/incident records. Staff were recording where people had an accident but information we saw was limited. However we have been told additional information on people's records was recorded. We identified one person with some bruising which was unexplained. An incident record had not been completed and there was no exploration as to how the bruising had occurred. Another person had fallen and was found in front of their wheelchair. When asked staff told us they were now in a chair which was safer for them. However, we were concerned that they had been able to transfer independently from their wheelchair but an assessment had not been completed to assess if their current chair was suitable for their needs or if they were still able to maintain their independence. We spoke with the maintenance staff who showed us all the regular checks they completed but this did not include visual checks on wheelchairs and walking frames to ensure they were in good working order. We have since been told this is the staffs responsibility but no visual checks were seen by the inspector.

In terms of Urinary Tract Infections we noted from the figures produced by the service that their rates of infection had increased. However this was felt to be because staff were more proactive in identifying the symptoms of a UTI, so early treatment could be offered. We looked at a number of fluid charts and saw a very high fluid intake for some people. Staff monitored people's fluid intake as required or where a risk had been identified. However when people first went into the service there was no specific recording of how much people were eating and drinking to establish a baseline of how much the person ordinarily ate or drank or if there was an identified risk. One person had recently come into the service and although it was felt they did not eat or drink well this had not been clearly established or monitored thus putting them at increased risk. We looked at a number of people's records and found some information inconclusive such as 'ate and drank reasonably well.' This would be difficult to evaluate as it is subjective. We noted that there were set times for drinks and people were not encouraged to drink in between these times. There was nowhere for people to put a drink as there were no side tables and drinks were not routinely left out for people to help themselves. This was a concern given the recent hot weather.

This demonstrated a breach in Regulation 12: a, b Safe care and treatment.

Improvements in the way people received their medicines were noted. Following our inspection in November 2015 the home was placed into special measures due to poor medication practices which placed people at risk of not receiving their medicines as prescribed which could result in harm. We inspected the service again in December 2015 and saw that the service had made the necessary improvements required. At this inspection we looked at medicines management again because we had received a number of concerns in relation to poor practices. Concerns included people's medicines not always being available when people needed them. In response we raised a safeguarding alert for one individual. During this inspection May 2016 we observed people being given their medicines at breakfast time. We saw that staff spent time encouraging people to take their medicines with a drink of water and in some cases asked them which order they preferred to take them in. However, some people did not receive their medicines until nearly 11.00am, only two hours before the lunchtime medicine round. This had the potential to put people at risk for example, for medicines in the treatment of Parkinson's and for administration of medicines such as paracetamol as there is a minimum gap of 4 hours suggested between doses. As staff recorded the intended time of administration rather than the actual time, they could not check that the correct interval was left between doses. This put people at risk of not receiving their medicines as prescribed.

Medicines administration records were completed correctly, although in some cases the cover sheet did not include a photograph and allergy status. One person had returned from hospital the previous day with a

large number of medicines which had been accurately transcribed on to a medicines administration chart and countersigned by staff.

There was a separate record for the application of creams which did not include information to guide staff on where to apply different products. One person was prescribed six different creams, only four of which were listed on the cream chart. The names of three of the creams were incorrectly written and there was no countersignature to show that this had been checked. There was a printed body map but it was blank and there was no record of where each cream had been applied. There were two tubes of a cream which staff told us was for the person's feet both tubes were still sealed. Another person was prescribed five creams, only three of which were listed on their cream chart. We could not be sure that creams were being applied as intended by the prescriber.

Body maps were used to record the application of patches but they weren't completed every time so staff were not able to check that they were leaving the correct interval between sites.

We noticed that one person did not have enough paracetamol in stock to last until the end of the cycle. We looked at records for the previous month and saw that the same thing had happened and the person had been without pain relief for five days until the next supply had arrived. Staff told us that the person need to take it more frequently now and the quantity had not been adjusted. In addition we have since had other concerns raised about people allegedly not having their prescribed medicines as required.

Medicines were securely stored and the temperatures of the storage room and fridge were recorded regularly, however the fridge thermometer wasn't reset after each reading to show that the temperature was within the correct range each day.

This demonstrated a breach of Regulation 12: f Safe care and treatment.

We found that a number of people had bruising as a result of falls and the service were proactively working to reduce the number of falls and unplanned admissions to hospital. We looked at the number of falls at the service and saw that these were minimal and evidence was provided that corrective actions were being taken to reduce further falls. They were involved in the PROSPER project. This is a project run by the Local Authority and set up to support homes to improve their practice and reduce the risk of hospital admissions due to falls, poor skin care and urinary tract infections, (UTIS). We spoke with the Local Authority who were happy with the services engagement and the service itself reported a reduction in falls From records viewed we saw people were regularly repositioned to help prevent a break- down of their skin which could result in a pressure ulcer. People were regularly offered fluids to help promote their hydration. There was also good monitoring of people's weight to ensure where people were at risk corrective actions could be taken by staff. The acting manager told us no one currently had a pressure ulcer but one person using the service recently had developed a pressure sore and this was subject to a safeguarding investigation. We do not have the outcome. However the service had not carried out their own assessment because it was an emergency admission and necessary equipment was not in place prior to the person's admission.

The maintenance person told us they checked the mattress settings but did not have access to care plans so could not check what settings the mattresses should be on according to people's needs and weights. The provider has since told us it is the care staffs responsibility to check the mattress settings but this was not made clear at the time of the inspection and records kept were made by the maintenance person.

Some bedrooms were cluttered. We felt this could pose an unnecessary risk for some people where there was an identified risk of falls. There was also limited signage. We identified one person who was confused

going downstairs for breakfast and getting in the lift to return upstairs within a few minutes. Staff then tried to take them back to their room when it was clear to us that they had not had their breakfast and we were able to intervene.

We found that there was a designated team managing the laundry and cleaning of the service. There was a head house keeper responsible for supporting staff with their training and supervision and there were checklists in place for daily cleaning duties. During our observations we found the standard of cleanliness were adequate and noted extensive refurbishment of parts of the service. For example the dining room had been recently refurbished and was light and clean. The kitchen had been recently redesigned with new stainless steel units making it easier to keep clean and recently got 5 star hygiene rating.

However we did note a number of areas for improvement including a number of bedrooms where the furniture was poorly maintained and not cleaned to a high standard. Odours were identified on entering the service and in some bedrooms and in the back corridor. The rotas for cleaning staff showed quite a wide variation with far less staff at weekends. However staff told us basic cleaning was done when there were fewer staff and more intensive cleaning when there were additional staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider has failed not notify us of all incidents that affect the health, safety and welfare of people who use the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always adequately assess or monitor risks, Regulation 12, 1, (a) (b) and did not always ensure medicines were available and given at the times needed. 12 (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to always provide sufficient numbers of suitable, qualified, competent, experienced staff to meet the needs of the people using the service.