St Andrews Care GRP Limited

Eckington Court Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 18 November and 8 December 2015 and was unannounced.

Eckington Court Nursing Home is required to have a registered manager. At the time of our inspection there was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service is registered to provide residential care for up to 50 older people. On the first day of our inspection 38 people were using the service.

Risk assessments and care plans were not always in place to ensure people received safe care. Where care plans and risk assessments were in place, staff did not always

Summary of findings

provide the care people required to mitigate risks to their health. People had access to other healthcare services, however where people experienced changes to their health they were not always appropriately referred for specialist advice.

Staffing arrangements had not been calculated to meet people's needs and as a result people experienced inconsistent care. People who relied upon staff to assist them with their care often had to wait for assistance. Not all people felt cared for safely because they had to wait for staff assistance.

Arrangements in place to ensure risks associated with medicines were mitigated were not always followed. People did not always receive effective pain relief and receive their topical medicines as prescribed.

Recruitment processes were checked to make sure staff working at the service were safe to do so. However records for staff training were not up to date and did not demonstrate staff had the skills to work effectively. In addition, staff had not received regular supervision or appraisal.

The principles of the Mental Capacity Act 2005 (MCA) had been applied, but applications for Deprivation of Liberty Safeguards (DoLS) had not always been made in a timely manner.

Staff did not always provide effective support to people who required assistance from staff with their meals and drinks. Staff were not always sure whether people had eaten their lunch and not all people who required prompting with their food and fluid intake received it. People's choices for food and drink were respected and people told us they enjoyed the food.

People were not always treated with dignity and respect because not all staff had implemented the principles of dignity and respect into their work. People were not always supported with their independence and did not always know the members of staff providing them with support.

People had opportunities to take part in activities and attend meetings organised by the activities coordinator. However, although people had voiced their suggestions and preferences they did not always experience improvements. People did not always receive responsive and personalised care including having a bath as frequently as preferred.

People had experienced a high turnover of managers running the service in the past year. The inconsistent management arrangements had contributed to a lack of leadership and direction at the service and a lack of support for staff.

Audits and systems designed to check on the quality and safety of services people received were ineffective and records were not complete, accurate or completed at the time care was provided.

In addition, the provider had not fulfilled its responsibilities to send statutory notifications about events that they are required to tell us about.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

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

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

Summary of findings

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

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from risks of unsafe care or the risks associated with medicines.

Insufficient staff were at times deployed and staffing was not planned to meet people's needs. Not all people felt cared for in a safe way.

Recruitment processes used to check staff were suitable to work at the service were effective.

Is the service effective?

Inadequate

The service was not effective.

The service did not have an overview of whether all staff were suitably trained to meet people's day to day needs effectively and staff were not supported with supervision.

People had access to other healthcare services, however referrals were not always made appropriately and care did not always follow care plans.

The principles of the Mental Capacity Act 2005 (MCA) had been applied, but applications for Deprivation of Liberty Safeguards (DoLS) had not always been made in a timely manner.

People do not always receive effective support from staff to help them with their meals and drinks. People's choices for food and drink were respected.

Is the service caring?

Requires improvement

The service was not consistently caring.

Not all staff implemented the principles of dignity and respect in their work.

Not all people had their independence supported.

The lack of consistent staffing affected the relationships people were able to build with staff.

Is the service responsive?

Requires improvement

The service was not responsive.

People did not receive personalised care, responsive to their needs.

People did not experience improvements to their care, or to the running of the service, even when they had made their views known.

People had opportunities to take part in activities and attend meetings.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Systems designed to check on the quality and safety of services people received were ineffective.

Records were not complete, accurate or contemporaneous.

The provider had not fulfilled its responsibilities to send statutory notifications about events that they are required to tell us about.

Eckington Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 18 November and 8 December 2015. The inspection team on the first day included three inspectors and a specialist professional nursing advisor. The second day of inspection was completed by a single inspector.

As part of this inspection we reviewed relevant information, including notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people who used the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We spoke with three people's relatives and ten members of staff, we also spoke with four members of the interim management team. In addition, we spoke with the local and health authorities responsible for the contracting and monitoring of some people's care at the home.

We reviewed 11 people's care records. We reviewed other records relating to the care people received. This included some of the provider's audits on the quality and safety of people's care, staff training, recruitment records, medicines administration records and minutes of internal meetings.

Inadequate

Is the service safe?

Our findings

People were not always protected from risks because care plans did not always reflect people's care needs or identify risks to people accurately. One person told us, "Different staff [assist me to move] differently." They told us they wanted staff to assist them in the way they preferred. We spoke to a member of staff who had assisted this person to move and they told us what equipment they had used. There was no risk assessment in place for the use of this piece of equipment. We made the interim manager aware of this issue so this person's needs could be appropriately risk assessed. The interim manager confirmed a review of this person's needs would be completed as a matter of priority. This meant the person was at risk as staff used equipment that had not been risk assessed to establish whether it could safely meet the person's needs.

Another person's care plan also stated staff should check on them each hour to maintain their safety. This was because they were cared for in bed and they were unable to use the call bell. A recent review confirmed that hourly observations were still required, however there was no evidence this was being completed as required.

We saw that one person had fallen seven times within a three week period. These falls did not trigger a review of the person's falls risk assessment or a medical review. The interim manager was not able to demonstrate that the physical observations of this person were considered in relation to these falls, such as the person's blood pressure from sitting to standing to help understand the falls and their cause. Another person had sustained a recent fall however, this had also not triggered a review of this person's falls risk assessment. Had this falls risk assessment been reviewed this would have elevated their risk level to 'high' and prompted a review of their care plan. Actions were not being taken to mitigate risks to people.

One person was diabetic and records showed they had lost one kilo in weight in 17 days. We were concerned that this weight loss had not prompted a review of their condition, any monitoring of their food and fluid intake, nor any change to how often their weight was monitored. We were concerned that staff had not taken any action to understand the cause of this significant weight loss. Actions to mitigate further risks to people were not being taken.

We reviewed the care provided to a person with a pressure ulcer. A care plan was in place for the dressings of the pressure ulcer to be changed on alternate days. We found three occasions where the person's pressure ulcer was re-dressed a day late. Dressings for pressure ulcers are designed to help with healing and should be changed as scheduled to ensure the dressings remain effective. Pressure ulcers of the level we found present pain and discomfort and their management requires close adherence to care plan guidelines to aid healing and the relief of pain and discomfort. Risks to people were not being reduced because people were not receiving appropriate care to their needs.

In addition, although the pressure ulcer wound was photographed no measurements had been recorded. Best practice would include measurements being taken of pressure ulcer wounds so as to be able to complete an evaluation of the healing process and to identify when the wound is not responding to prescribed treatments. The person also remained at high risk of developing further pressure ulcers, however their care plan had not identified further monitoring and skin checks that were appropriate to the person's high risk of developing pressure damage. Appropriate monitoring and testing of a person's skin can identify any early signs of tissue damage developing allowing for further reduction of risks to be taken.

We reviewed the care provided to another person identified as being at high risk of developing pressure ulcers. They used a pressure relieving mattress and staff were required to re-position this person every two hours to help prevent the development of pressure ulcers. Records did not support that the person was repositioned every two hours as required. We found on some days the person was not repositioned for over three and a half hours and on one day the person had not been repositioned for over eight hours. Another person who required repositioning every two hours was found to have not been repositioned for five hours. Records also showed people's pressure relieving mattresses' were not checked daily to ensure they were functioning correctly.

Some people were assessed as requiring their fluid intake monitoring. Records showed people's fluid intake was low. For one person their fluid intake chart indicated a very low fluid intake for the ten days prior to our inspection. There was no evidence that this had been bought to the qualified nurse for any action to be taken. For another person whose

fluid intake was low, the nurse in charge of the shift had not signed to say they had considered the records made and what action was required to mitigate risks to these people as appropriate.

Procedures designed to help ensure the safe management of people's medicines were not being followed. We found that one person had not received their pain relieving medicines as prescribed. This person's pain relief was delivered through the application of a patch and records showed, and staff checked and confirmed, that the application of a new patch was a day late. This person's condition meant that they would experience pain and discomfort on moving and during any washing or dressing. We were concerned over the levels of pain the person may have experienced because their pain relief was a day late and we made the interim manager aware of our concerns.

One person told us, "Sometimes staff watch me taking my tablets as I might forget but sometimes they don't." This person still had their morning medicines left by their side when we went to talk with them, after 10.30am. The staff member responsible for administering medicines had not stayed with the person to ensure they took their medicines as prescribed. This person also told us, "[My morning medicines] may be from 8am to 10 and 11am, no fixed time."

Some people required their medicines to be administered when they needed them, rather than at specific times of day. Arrangements were not in place to help staff make consistent judgements on when people required this certain type of medicine. This included medicines prescribed for end of life care and management of anxiety. Guidelines were in place for 'as and when required' pain relief, although these were not supported by staff practice. This was because they were based on staff monitoring people's pain levels using a recognised pain scale, however no formal monitoring of people's pain levels was being completed by staff. This meant people may not receive effective pain relief or effective management of their anxiety when required.

We saw that one person also had some topical cream prescribed to be applied two to three times a day. The medicines administration record (MAR) chart stated this was to be applied by care staff. There was no chart in this person's room for care staff to record this had been applied as prescribed. Therefore we were not assured this person was receiving their medicine as prescribed.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke to told us they often had to wait a long time if they requested assistance from staff. One person told us, "Staff agree to fetch me something but forget. I may have to wait half an hour for something. Some residents may wait this time when they want the toilet. This [delay] happens regularly. We have less attention now." During our inspection one person told us, "I'm waiting for a cup of tea." We saw this person was still waiting for their cup of tea 20 minutes later.

Another person told us they needed staff to help them with their mobility. They told us, "You might wait ages," and, "Staff do help but they tell you, 'I'll be back in a minute,' and twenty minutes later no-one has turned up, it's no help at all. Staff just disappear." One family member also told us they were worried that staff were not always available to go to hospital appointments with their relative.

Some staff we spoke with told us they felt under pressure because of the staff shortages. One staff member told us, "I'm rushing all the time to check if people are okay. I find it frustrating and I'm not doing my job properly." Another member of staff told us staffing levels were an issue but they thought the staffing levels had been increased recently.

The interim manager who provided management cover on the day of our inspection told us that there had not been enough staff to support people when they first started to cover at the service at the start of November. They told us they took action to increase the staffing levels, however they were unable to tell us how they calculated the amount of staff required to provide support to people. We were shown a staffing dependency tool for April 2015 however this did not accurately reflect the current needs of people using the service. For example, it only showed two people required staff assistance at meal times. During our inspection staff told us twelve people required staff assistance at mealtimes. We were not assured that the numbers of staff and their deployment was based on any understanding, by the interim manager, of the needs of people who used the service.

We observed staff under pressure when providing support to people. For example, a member of staff administering lunchtime medicines was repeatedly told other staff

Is the service safe?

required their assistance and they stated, "[People] will get their [medicines] at 4 o'clock at this rate." We observed some people receiving care in their bedrooms were served their breakfast at 10.25am. We were told this was people's preference however we found nothing in people's care plans to confirm this. At 12.45pm we heard staff talking about people who required their dinner in their room, they said, "No-one's had dinner yet, [I'm] just going down [the] corridor." We saw one person was assisted by staff to start their main meal at 1.20pm. This did not assure us that adequate staff were deployed so that people received their meals in a timely manner and according to their preferences.

Although we were not assured that the current amount of staff working in the service had been calculated based on the needs of people using the service, we still reviewed staff rotas. Some staff and families had told us there had been times, recently, where there had not been many staff working to support people. We reviewed staff rotas from the start of November 2015. We found one occasion when just four members of staff had been shown to be at work during the day. We also found that the numbers of staff shown on the rota varied. For example, from the start of November 2015 to the time of our inspection, between three and five staff were shown to work at night and between four and nine members of staff were shown to work during the day. We were concerned that people's needs were not being safely met on the days when just four members of staff were shown to have been on duty. Staff were not planned and deployed on the basis on meeting people's needs safely.

One family member told us they were concerned that staff did not have the time to support their relative to take sufficient amounts of food and drink. During our inspection we saw one person ate very little of their lunch and that they received no encouragement from staff to eat their meal. The care plan for this person stated they needed much encouragement to eat and drink as they were at high risk of taking inadequate food and fluid. Staff had not been deployed to provide adequate encouragement to this person to support them to take an adequate food intake as identified in their care plan.

When we arrived for our inspection, no care staff were available to answer the door. We waited for five minutes and then were let in by another member of staff who had just arrived to start work. There was an 'out of hours and weekend' notice on the door advising people that if no-one has been able to let them in after five minutes they should phone the office number to request assistance. During our inspection, we also phoned the office number, in office time, to request further information. However, after over five minutes of waiting for our call to be answered no-one answered the phone. Staff were not available to always answer the door and phone in a timely manner.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines were administered from pre-prepared packs which stated the date the medicine should be administered on. We found that people's medicines had not always been taken from the correct section of the packs. This resulted in medicines being signed for as being administered however the medicines for that day still remained in the pack because the member of staff had taken medicines from another day. Whilst these were not administration errors the failure to take medicines from the correctly dated packs introduces a risk of a medicines error occurring.

We found special administration arrangements for some medicines were being followed and this ensured people received these medicines as prescribed. We also found a negligible use of medicines to control mood and behaviour, in line with good practice guidance.

People's views on whether they were cared for safely were mixed. One person told us, "I feel cared for safely." However another person said, "I would feel safer if [staff were] with me [when I need help]." Staff we spoke with told us they had completed safeguarding training however the training matrix was not up to date so we were unable to confirm all staff working at the service had completed the required training. Staff recruitment files showed that staff employed at the service had been subject to pre-employment checks. These helped to ensure staff were suitable to work with people using the service.

Inadequate

Is the service effective?

Our findings

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 MCA's were in place for specific decisions, for example, for when one person refused their medicines.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The interim manager told us they had applied for 14 DoLS for people living at the service. We looked at the application process for one of the people where a DoLS application had been made. We found a decision had been made in February 2015 that a DoLS application was required for this person. However the DoLS application was not completed until May. There was nothing recorded in the person's records to explain the delay. In addition, the interim manager did not know why this delay had occurred. This meant that the person had been at risk of experiencing unlawful restrictions on their day to day life for three months. The delay in applying for a DoLS meant that the person was not offered the appropriate safeguards under the Act in a timely manner.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not be assured that all staff had completed relevant training as the interim manager told us there was not an up to date training matrix. The training matrix we were given did not accurately reflect the staff who worked at the service. For example, one member of staff had started work at the beginning of September 2015, however they were not included on the training matrix we were given. When we spoke with this person they told us they had completed some on-line training but still had some more to complete. The interim manager told us that any on-line training completed by staff was followed up by a manager observing staff practice. However, the interim manager could not confirm this had been completed and we found no evidence of competency assessments in people's training files. When we spoke with staff they told us arrangements to support staff competency, such as supervision had not happened recently. We could therefore not confirm they had completed all the necessary training as required by the service. In addition, some staff who worked at the service and who were on the training matrix were not recorded as up to date with all the training required.

We found staff had not received recent supervision or an appraisal to support them in their role. One member of staff told us, "There's no team meetings, no supervision, all out the window." One member of staff had not received supervision since February 2015. Two other members of staff had not had supervision since April and May 2015. Supervision and appraisal helps staff to identify any further support or training required and provides staff with an opportunity to raise any concerns. The interim manager told us staff should receive supervision six times a year, however this had not happened with the previous management arrangements. Although they told us they had identified this as an area for improvement, and that an action plan was in place, we were not assured that improvements would be able to be implemented with immediate effect. We were therefore not assured staff received the support, supervision and training to carry out their roles and responsibilities effectively.

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

People who required a member of staff to assist them with their meals received variable levels of care. We observed that some people who could not communicate with us had preferences for certain members of staff to support them with their meals. We observed one person refused help with their meal from one staff member but would accept help from a different staff member. However because this person's preferred staff member was also supporting another person with their meal as well as serving food, they were not able to continue to provide support to the person. This meant that the person continued to receive support from another member of staff and they demonstrated less enthusiasm for their meal.

We also saw that people who required staff to support them with their meals in their own rooms, received their

Inadequate

Is the service effective?

meal later than people who could eat independently in the dining room. Staff were sometimes confused as to whether people had eaten their meals. We observed some confusion between the staff in the dining room as to whether one person who arrived late for lunch had already eaten their lunch or not. It took staff over five minutes to decide the person needed their meal and being one to them. Another person, who was at risk of taking inadequate amount s of food and fluid received very little prompting by staff to eat their meal. One family member we spoke with told us they felt staff did not have time to assist their family member with their meals and drinks.

People who were able to tell us their views, told us they enjoyed their meals and could make choices that met their preferences. One person told us for their breakfast, "I've had cereals and pikelets, I've enjoyed it." Another person told us, "[Meals are] lovely, we have plenty and choices." One family member we spoke with told us, "[My relative] enjoys [their] food, [they have] cereal and a cooked breakfast in the morning then a big cooked dinner at lunchtime and sandwiches or a snack type tea later on…[They have] had a choice of pie or gammon today." However, one person told us they thought standards had slipped and the food was of less quality now.

We saw that people who required a specific diet, such as to manage their diabetes or because of their individual preferences had those needs identified in their care plans. We also observed people who required aids, such as plate guards, to help them eat their meals with more independence, had these provided. People were also offered different choices of main meals and people's individual requests for alternative food and drink were provided for.

One person told us they saw the district nurse and that a GP visited the service regularly. Another person told us they saw their GP on a Thursday if needed. One person understood their specific health condition and knew they had a hospital appointment booked. Care plans recorded where GP's had reviewed people's care and prescribed additional medicines when needed. We also saw people had seen opticians for reviews of their optical prescription.

However, we were not assured that referrals to appropriate healthcare services to enable people to maintain good health were always made appropriately. This was because we found one person had experienced frequent falls and we found that no referral for specialist advice, such as to a falls clinic, had been made.

Requires improvement

Is the service caring?

Our findings

People told us they felt staff cared for them in ways that were respectful and promoted their privacy and dignity. Most of the time we observed staff speaking to people with respect, however we observed staff did not always ensure respectful terms were used when speaking amongst themselves and where they could be overheard by people using the service. We heard one staff member ask another staff member, "Can you do a feed for me?," when referring to a person who required staff assistance when eating their meal.

We saw families were able to visit people and could spend time with people in either communal areas or in their own rooms for privacy. However, we found that some staff worked in ways that did not always promote people's independence. For example, one person told us they liked to put out their clothes in their bedroom for the next day. However they told us staff would gather these up without asking and take them into the laundry. The person said, "If they'd just ask." Staff were not working in a way to support this person's independence.

In addition, on the first day of our inspection a display to orientate people living with dementia to the day and date was out of date by two days. This display told people it was Monday when it was in fact Wednesday. This was did not support people to be independent because it did not orientate people to the correct date.

Most people told us they thought staff were caring. One person told us, "Nurses and care staff are pleasant and helpful," another person told us, "Yes, [staff] are lovely." Some people however, felt the changes in the staff group affected the relationships they were able to build with them. However, one person commented that staff varied and another person told us, "I don't get introduced to new staff."

We saw that staff supported one person to keep a pet and we could see the person had been involved in how staff supported them to care for their pet. Staff planning activities knew people's preferences and took into account people's religious beliefs when planning events and activities. Minutes of a meeting with people using the service showed that staff had bought in some sweets that they knew people liked. Staff respected people's views when these were known.

Requires improvement

Is the service responsive?

Our findings

One person we spoke with told us, "I had a bath yesterday, what a treat," and, "It's my first since I arrived here," and, "I don't feel clean in here." This person had been in the service for over three weeks and their personal hygiene charts had not recorded any bath previous to this date. They went on to tell us, "I didn't know I was having one until [staff] turned up." We checked the bathing records for two other people using the service and found that one person had not had a bath in a week, and another person had received one bath in nine days. Although records showed people had their personal care needs met, this was not always in a way that met with their preferences. We also spoke with one person who was spending time in their room. We found their nurse call bell was out of reach. Their care plan stated their nurse call bell should be available for them to use. People were at risk of not receiving personalised care that met their needs.

One person told us they had a window in their bedroom that was difficult to open. They told us they had mentioned this to the previous registered manager once before, however they were unsure if anything had been done to mend the window as it was still very difficult for them to open and close. Staff had opened another window that morning and the person wanted the window closed as the wind was blowing the curtain and had knocked over their ornaments on their window sill. They told us, "I try to keep things ship shape." The window in this person's room had not been improved as requested.

We saw areas of carpet in communal areas and in a person's room had staining on them. We saw one person had mentioned they wanted their carpet cleaning in a residents' meeting at the end of October 2015. They were told staff were waiting for the carpet cleaner to be repaired. When we checked with this person they showed us that the marks on the carpet were still there. During our inspection the interim manager told us both carpet cleaners were not in use and they were making arrangements for the carpets to be cleaned. However the person had originally raised their request for carpets to be cleaned over one month ago. People did not always experience a timely response to their requests to improve the service.

At the meeting with people using the service in October 2015, one person had requested that all staff assist them in a consistent way. When we spoke with this person they told us they still experienced different members of staff assisting them in different ways. This person told us they had a preferred way of being assisted and not all staff provided care in this way.

Another person told us they had requested to be woken up at a particular time each morning, rather than at random times. However they told us there had been no change to their morning routine since they had made this request. People did not always receive personalised and responsive care to meet their needs, despite contributing their views.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a copy of the complaints process was on display at the service and we saw that people raised concerns when needed. We saw a complaint had been made over two months before our inspection about the length of time it took staff to answer the front door when families called. During our inspection we also experienced a five minute wait before we were let into the building. We were not assured that the service had improved based on people's feedback.

We saw a written complaint had been received by the service however we could not see how this had been responded to. We asked to see the response. We were told there had not been a written response however one of the interim managers had met with the complainant although this had not been documented. It had been over one month since the original complaint had been made. We were therefore not assured complaints were being responded to appropriately or evaluated and used as opportunities to improve the service.

The results of a recent questionnaire sent to people, their families and staff were on display. People we spoke with could not recall seeing a questionnaire. The interim manager told us this was done eight weeks ago, however they were organising for the survey to be repeated. They told us this was because they were not confident the survey results were accurate.

We found that activities were available for people and meetings were held with people using the service. One person told us they had attended a recent autumn fair. We saw posters advertising meetings with people and we saw minutes of the meetings that confirmed people attended.

Requires improvement

Is the service responsive?

During our inspection a hairdresser had visited and was available for people to have their hair washed and styled. People had opportunities to contribute their ideas for events and activities that they were interested in.

Inadequate

Is the service well-led?

Our findings

Not all people we spoke with knew what management arrangements were currently in place. One person we spoke with told us, "[The service] feels well managed when there is a manager. I don't know who is managing at the moment." One relative told us, "They've just got rid of a brilliant manager, …they've had [X] managers since my [relative] was in here, they can't keep them," and, "They never tell [us relatives] either, you just turn up one day and there's someone new here and it's like, "Who are you', it's not good."

Eckington Court Nursing Home is required to have a registered manager, however at the time of our inspection this requirement was not being met. On the first day of our inspection we were told a new manager had been appointed, however by the second day of our inspection we were informed that this had not been successful. We were told that another candidate was now going through the interview process. Three managers had left service during 2015. Some staff we spoke with told us the management arrangements felt uncertain and as a result staff had not received the support of team meetings or supervisions. We were concerned that the service was not receiving consistent management leadership, support and direction.

In the absence of a manager, cover was being provided by interim managers. This was being shared between two registered managers from two of the provider's other services, an area manager and a peripatetic manager. On the first day of our inspection, 18 November 2015, we were told the provider had completed an audit and identified actions required to secure improvements. On our second day of inspection, 8 December 2015, we looked at whether the provider was achieving the improvements stated in their action plan. One target had been for staff supervisions to be bought up to date. We checked three staff files and found that their supervision was still not up to date. We spoke with the interim manager who told us they had not been able to complete the actions identified due to the number of visits made by other professionals to review people's care. We were concerned that actions to improve the service were not being addressed because the provider had not been able to meet the targets set in their own action plan for improvements. We were concerned that adequate resources were not being provided to secure the improvements required. We were not assured that systems and processes were established and operated effectively to assess, monitor, mitigate risks and improve the quality and safety of services provided.

Systems and processes to check on the quality of care provided were not always effective. Our inspection found care plans and risk assessments had not always been updated to reflect changes in people's health and care needs. Prior to our inspection, in September 2015, the provider sent us a 'provider information return' (PIR). This stated that care plans were reviewed and evaluated on a monthly basis, or more frequently should there be any immediate changes. It also stated that risk assessments were in place and were updated and that care plans were audited on a regular basis. In addition, it stated that the service had monthly and bi-monthly audits and a provider audit completed by the regional manager each month. The systems described in the PIR were ineffective as we found care plans and risk assessments had not been updated to reflect changes to people's needs. Nor had any care plan audits identified that information on people's needs was not current and accurate. In addition, no audits, prior to the interim management team covering the service, had identified staff were not monitoring people's levels of pain as required by their care plans. Nor had the variation in staffing levels been identified and analysed to identify improvements.

We also found reviews of other documents, including those to support people's decisions around their end of life choices had not been maintained in line with national guidance. National guidance states that full and clear documentation of decisions about choices such as cardio-pulmonary resuscitation (CPR) should be accurate and up to date. We found people did have decision making agreements in place for resuscitation choices, however we found one person's decision making agreement required a review in June 2015. No review was recorded as being held. Therefore we were not assured that this documentation was valid. Systems and processes were not effective to assess, monitor, mitigate risks and improve the quality and safety of services provided.

The PIR also stated that staff would have bi-monthly supervisions and that the provider listened to staff at staff meetings. We found staff supervision was not up to date. We looked at three staff supervision files and found that the three staff had last had supervision in February, April and

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May 2015. Staff told us supervision had not been happening regularly. We asked to see evidence of staff meetings and the covering manager told us 'flash meetings' were held however, these did not include all staff. We found no evidence of meetings held with all staff. We were not assured that the information we had been provided with in the PIR was accurate and complete.

We found records of people's care and treatment were not always made at the time it was provided and we could therefore not be assured that the records were accurate and complete. One person's care plan stated they were at high risk of taking inadequate food and fluid to maintain a healthy status. We checked their food and fluid chart in the afternoon at 3.40pm. Their fluid chart stated they had taken 200mls of tea at 10am and had eaten all of their breakfast. We observed this person had received their lunch however no detail had been filled in to record how much they had taken. Staff told us incomplete record sheets were left out for staff to complete retrospectively at the end of their shift and this person's sheet had been left out of staff to complete. The lack of maintaining accurate, complete and contemporaneous records may place people at risk of inappropriate or unsafe care because their well-being cannot be monitored effectively and the accuracy of retrospective record making cannot be assured.

Records for kitchen staff on people's special dietary requirements were not accurate and had not been updated to reflect changes in people's needs. Kitchen staff told us one person required a liquidised food diet and had required this diet for the last three months. They showed us the 'diet notification' sheet kept in the kitchen for this person. It was eight months old and made no reference to the current needs of the person. There was a risk that other staff would use the out of date 'diet notification' sheets to prepare food for this person which would have the potential to cause significant harm.

We found other records, such as risk assessments were also inaccurate. For one person, staff had not included, on three separate occasions, an additional risk category in their calculation of the person's falls risk assessment. Another person's dependency assessment was calculated incorrectly. Whilst this would not have changed the overall category of risk for these people it is important for risk assessments to contain accurate information so that any further changes in need can be calculated accurately. In addition, the interim manager also told us they were concerned that the recent satisfaction survey sent to people, their families and staff was not accurate. It is important for all records relating to people's care or to the running of the service to be of reliable quality and accurate.

Daily records were found not to have always recorded significant events. We found daily records did not record that one person had fallen on two occasions. Food charts were also not completed in a way that would allow adequate and accurate monitoring of the quantity of food intake. We found records that showed a lower than expected fluid intake for people had not been signed off by the nurse in charge of that shift. The service also required the temperature of the medicines fridge to be taken twice a day to ensure medicines were being kept at the required temperature. We found days where the temperature had not been taken at all, and during October there were only 11 days when the temperature was recorded twice a day as required. Records had not been reviewed and used to evaluate the effectiveness of care delivered. Nor does it support that they were used to evaluate and identify any changes or improvements required to people's care and the quality of services provided.

Systems to monitor the cleanliness of the service were also ineffective. Although cleaning staff recorded what cleaning tasks they had completed each day they did not have a pre-planned schedule of cleaning to follow to ensure all areas of the service received the required level of cleaning. In addition, both carpet cleaners were not in use and as a result there had been delays to cleaning areas of carpet. Adequate equipment to ensure good infection, prevention and control was not maintained. For example, a schedule for when separate areas were deep cleaned or when curtains, carpets and high ledges had been cleaned.

Audits had not identified discrepancies in staff practice regarding infection control. Staff told us there was not a separate hand wash sink in the downstairs sluice room and that they were washing their hands at different hand wash facilities. This is not in line with good practice as it introduces the risk of spreading infection from after using the sluice. The interim manager told us that they expected staff to use the hand wash sink adjoining the sluice, however they had not identified that this practice was not being followed nor that there were no paper hand towels supplied in this area on the day of our inspection for staff to

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effectively decontaminate their hands. We were therefore not assured that systems and processes were established and operated effectively to assess, monitor, mitigate risks and improve the quality and safety of services provided.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, the provider had not always fulfilled its responsibilities to send statutory notifications to the Commission. Notifications are changes, events or incidents that providers must tell us about. We were informed that a member of staff had previously lifted a person incorrectly and unsafely. This incident would be classed as an allegation of abuse. We were not notified by the previous registered manager about this incident.

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

We saw that families visited freely during our inspection, however not all families we spoke with were confident in the current interim management arrangements at the service. We saw that people using the service had received opportunities to discuss issues however we did not see evidence that their contributions resulted in changes for them. Staff had limited opportunity to contribute to the development of the service because team meetings to include all staff were not held and staff had not received recent or regular supervision and appraisal. The management and leadership at the service had not taken effective action to ensure the service was developed and improved by the people using it, their families and staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Service users did not receive care and treatment that was appropriate and met their needs and preferences. Care and support was not designed to meet people's preferences and ensured their needs were met. Regulation 9 (1) (a) (b) (c) (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users did not receive care and treatment provided in a safe way. Risks to the health and safety of service users were not always assessed and not all actions that were reasonably practicable were taken to mitigate any such risks. The proper and safe management of medicines was not always followed. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively to ensure the quality and safety of

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Action we have told the provider to take

services provided was assessed, monitored and improved. Systems and processes were also not established and operated effectively to ensure risks relating to the health, safety and welfare of service users and others were assessed, monitored and mitigated. Records regarding the care and treatment of service users and other records necessary for the management of the service were not accurate, complete or contemporaneous. Feedback from service users and other relevant persons had not been used for the purposes of continually evaluating and improve both practices in processing information and the service. Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed to meet people's needs. Persons employed by the service did not always receive appropriate support, training, supervision and appraisal to enable them to carry out their duties they were employed to perform. Regulation 18 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not fulfil its responsibilities to send statutory notifications to the Commission. This was a breach of Regulation 18 (1) (2) (e) of the Care Quality Commission (Registration) Regulations 2009.