Worcester Garden (No.2) Limited

Garden House

Inspection report

24 Humberston Avenue
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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**

Summary of findings

Overall summary

This inspection took place on 10 and 11 April and was unannounced on the first day.

Garden House is registered to provide residential care for up to 40 older people. Accommodation is provided over two floors with both stairs and lift access to the first floor. An area of the service, 'The Devonshire Suite' provides support for up to 12 people living with dementia. The home is situated in Humberston, a suburb to the south of Grimsby.

Garden House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. At the time of this inspection 17 people were using the service.

At the last inspection on 17 and 21 November 2017, we rated the service as 'Requires Improvement' and we asked the provider to take action to make improvements in relation to person centred care, safe care and treatment, consent and good governance. Following the last inspection, we received an action plan and we met with the provider to discuss what they would do and by when to improve the key questions Safe, Effective, Responsive and Well-Led to at least good.

After receiving a number of safeguarding alerts about the home and information of concern from North East Lincolnshire Clinical Commissioning Group following their recent monitoring visits, we undertook this inspection. We found people were still not provided with safe care. Management of the service was disorganised and chaotic and there continued to be insufficient governance to mitigate the risks to people's health, welfare and safety. We found multiple concerns and are considering our regulatory response. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Immediately following our inspection, we formally notified the provider of our escalating and significant concerns. We asked the provider to tell us what urgent actions they would take with immediate effect to mitigate the risks we identified at this inspection. For example, in relation to the risks of poor staffing levels, the mismanagement of people's medicines and the unsafe moving and handling practises we had observed. We received a response with their improvement action plan on the 18 April 2018; this was not within the timescale requested.

There was no registered manager at the service. The registered manager had resigned and left the service in November 2017. A new manager had been appointed to the service in January 2018 and had resigned and left the service eighteen days before the inspection. A registered manager is a person who has registered with the CQC 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.

There was a lack of managerial oversight at all levels. There were shortfalls in how the service was managed overall and how care staff were overseen and supported when carrying out their roles. The office and recording systems were disorganised and some confidential information was not being stored securely. The provider had failed to ensure all statutory notifications of events and changes in the service had been submitted to the CQC.

We were told by staff and relatives and we saw evidence that there was a continued high turnover of staff, which was a concern. Appropriate recruitment procedures were not in place to ensure staff employed to work at the home were safe working with vulnerable people.

People were not always protected against the risks associated with the unsafe use and management of medicines. Some people had not received their medicines as prescribed due to errors in administration and non-application of creams.

There was a lack of robust risk assessment and management; people did not always receive safe care and support. Management oversight failed to ensure staff always followed policies and procedures, outcomes from risk assessment or sought and followed guidance from other health professionals.

There were concerns with the management of infection prevention and control due to the strong mal-odour present in one person's room, the risk of cross contamination due to the build-up of laundry and staff's inconsistent use of personal protective equipment and standards of hand hygiene.

There were not enough staff deployed to meet people's needs. Staff rotas showed the levels of care staff frequently fell below the levels the regional manager told us were in place. We found staff were kind in their approach with people. However, most of the interactions were only brief as they were busy meeting people's personal care needs. At times people had to wait for assistance and staff were not always present in communal areas to ensure people's safety.

Training and induction of staff was not sufficient to ensure staff had the competencies and skills to meet the needs of people who used the service. Supervisions were not taking place regularly, which meant staff were not always appropriately supported in their role.

We found there was an inconsistent application of mental capacity legislation. Some people had assessments to determine their capacity to consent to specific restrictions such as bed rails, but others did not. Documentation showed best interest decision-making had not been completed appropriately. There were four people whom we felt should have been assessed to see if they met the criteria for a deprivation of liberty safeguard; they were living with dementia, resided in the Devonshire Suite and staff said these people wouldn't be able to leave the home freely, as it would not be deemed safe for them.

Opportunities for people to be supported to lead meaningful lives and to participate in social activities of their choice and ability, particularly for people living with dementia were very limited.

People told us the staff were kind and caring, although they said some staff were better than others. Our observations identified people's dignity was not always preserved.

Staff did not have up to date information about people's individual needs which meant important person-centred care could be missed. There were gaps in some people's monitoring records for their food and fluid intake, weights, repositioning, bathing and bowel movements. Not everyone who used the service had a care plan and there were gaps in care planning for other people. Also care plans were not always updated

when people's needs changed and advice from health professionals was not transferred to the care plans.

People and their relatives told us that if they had any concerns they would discuss these with the management team or staff on duty. We saw a complaint had been received recently and managed in line with the provider's procedures, however the senior management were not aware of the concerns and the complaints file and records were unavailable to evidence all complaints received and the actions taken to resolve these.

Staff knew how to recognise and respond to abuse although one member of staff was not aware of the external agencies they could contact. The service notified us of safeguarding incidents. There were a number of safeguarding concerns raised in recent weeks being investigated by the local authority safeguarding team.

The breakfast meal experience for some people on the first day of the inspection was poor, due to the length of time waiting for their meal. We saw meals were nicely presented and menus provided choice and alternatives. Staff supported people to eat their meals in an appropriate way and at a suitable pace for them. People told us they liked the meals provided to them.

The culture within the service did not promote a holistic approach to people's care to ensure their physical, mental and emotional needs were being met. Robust audit and monitoring systems were not in place to ensure that the quality of care was consistently assessed, monitored and improved. Quality assurance systems had failed to drive improvements from the last inspection or identify the majority of concerns we found during this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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.

Systems and processes in place were ineffective to ensure people received their medicines safely as prescribed.

Risk had not been managed effectively, which had placed people who used the service at risk of harm and injury. Appropriate standards of hygiene were not being maintained.

Recruitment processes were not safe and there were not enough staff deployed consistently to ensure people's needs were met and they were safe.

Staff knew how to recognise and respond to abuse, although one member of staff was not aware of the external agencies they could contact. The service notified us of safeguarding incidents.

Is the service effective?

Inadequate

The service was not effective.

Some people's health care needs had not been reviewed or managed appropriately. This placed people at an increased risk from receiving care and support that was not appropriate to meet their needs.

Staff training was not up to date and some staff lacked essential knowledge to enable them to support people effectively. Staff were not appropriately supported in their role through regular supervisions.

Staff did not always follow legislation designed to protect people's rights.

People told us they enjoyed the meals. They were supported to eat and drink enough; however, food and fluid intake was not always adequately monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff treated people with respect, but we observed that staff did not always treat people in a way that preserved their privacy and dignity.

Personal information was not always stored securely.

Staff were observed as having a kind and caring approach and people spoken with confirmed this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all people who used the service had a care plan in place detailing their care and support needs. People's care plans lacked important information about how care was to be delivered in a person-centred way.

People who used the service were not engaged in meaningful activities or supported to pursue activities and pastimes that interested them.

The provider had a complaints policy and procedure and people felt able to raise concerns. The complaints record was not available to evidence all complaints received and the actions taken to resolve these.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight at all levels and there had been further management changes at the service.

An effective quality assurance system was not in place. This had led to breaches of multiple regulations. Audits conducted had not been robust and action plans were not in place to drive continuous improvements to the service. The provider had not notified CQC of all significant events.

There was not a positive culture which fully reflected the best interests of the people it served.

Garden House

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 and 11 April 2018 and was unannounced on the first day. The inspection team consisted of a pharmacy inspector, two adult social care inspectors and an inspection manager.

Before the inspection we reviewed information available to us about this service. We had not requested a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed safeguarding information and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury. We contacted the local authority safeguarding and quality performance teams to obtain their views about the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at mealtimes. We spoke with eight people who used the service and two people who were visiting their relatives or friends. We spoke with the director, regional manager, acting manager, deputy manager, three senior care workers, three care workers, the cook, two domestic staff, the maintenance person and six visiting healthcare professionals.

We looked at eight care files and at other important documentation relating to people who used the service. We looked at how the provider managed people's medicines and we checked records to ensure the provider was compliant with the Mental Capacity Act 2005.

We looked at a selection of documentation relating to the management and running of the service. These included staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2017, we found people were not being protected against the risk of unsafe care, particularly in relation to the management of medicines. We concluded this demonstrated a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to inform us of the actions they would take to address our findings, protect people and raise standards. At this inspection, we found improvements had not been made and there had been deterioration in other areas.

At this inspection a pharmacist inspector looked at medicines and associated records for six people who used the service. Although a new medication system had been put in place, we identified similar concerns to the last inspection. We found systems for managing medicines at the service did not always keep people safe.

We were concerned that some people were not given their medicines as they had been prescribed by their GP. For example, one person had been prescribed a course of antibiotics to be taken twice daily for three days. We found this had been given three times on 2 April 2018. In addition, the antibiotics were continued for five days which was longer than the instructions the GP had given in the prescription. For another person, we found medicines had been signed as given on two days in April 2018, but they were still in the blister pack in the medicines trolley on the day of our inspection. These included medicines for heart disease, a blood thinner, an antidepressant and a medicine for thyroid disease. A third person's medicines had been signed for one day in April 2018 and not administered. Not giving these medicines regularly as prescribed poses a risk to the safety and wellbeing of the person.

We found staff did not always complete medication administration records (MARs) accurately to reflect the treatment people had received. For example, we found 33 gaps between 26 March 2018 and 9 April 2018 on the six MARs we reviewed; staff had not signed to confirm that a medicine had been given or entered an appropriate code to record non-administration. We found other shortfalls with the recording of controlled drugs and medicines which required refrigeration.

Some people were prescribed medicines to be taken as and when required (known as PRN). We found there was a lack of supporting information to guide care staff how and when to administer these medicines, for example the minimum dose interval or what action to take if the medicine was ineffective. In addition, when a variable dose was prescribed, staff did not always record the amount they had given on the MAR. This meant records did not always reflect the treatment people had received.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. We checked care records and found care staff had not made records to confirm they had applied these treatments as they had been prescribed. A person was being given their medicines crushed and sprinkled on soft food. Care staff told us they were not disguising the medicines and they explained which medicines they were giving to the person on each occasion. However, written guidance was not available about how to safely crush and administer these medicines to ensure this practice was safe.

One person was prescribed a fluid thickener to be added to their drinks to reduce the risk of choking. We found care staff did not record when they had added thickener to people's drinks. On one occasion we observed the person was coughing and choking when taking their medicines with a drink, the thickening agent had not been mixed in thoroughly. The day before the person's beaker of tea had been too thick for the person to drink easily. This showed staff were not checking the consistency of the drinks to ensure they were safe.

We found concerns with the management of infection prevention and control at the service. There was an overpowering malodour in one room and the carpet was stained. Domestic staff could not confirm how often the carpet had been cleaned and explained they struggled to manage the odour.

We identified there was inconsistent provision of paper towels, liquid soap and pedal bins in bathrooms and people's rooms to support effective standards of hand hygiene. We also observed poor staff practice in relation to hand hygiene and the use of personal protective equipment. For example, we saw a care worker did not wash their hands after they had emptied a commode pot in the toilet, then rinsed the commode pot in the sluice room and before they went into the kitchenette to prepare breakfast.

Systems and processes were inadequate to ensure people's laundry was clean and free from the risks associated with cross infection. During both days of the inspection there was a considerable build-up of laundry and we observed soiled laundry was piled next to clean laundry. There was no dedicated laundry assistant. The regional manager told us most laundry duties were completed by night staff. They told us care staff and domestic staff completed the laundry duties during the day, when they had time.

People's care was not co-ordinated or managed to ensure their specific needs were being met safely. Individual risk assessments were not always in place, accurate or up to date and effective care planning strategies were not always in place in relation to people's physical and mental health needs. Staff did not have sufficient guidance on the support people required to meet these needs and keep them consistently safe.

Records to ensure people received appropriate support from staff and equipment to safely move around the home were not reflective of their current needs. We observed poor moving and handling techniques by staff on two occasions, when they failed to follow the guidance of the community occupational therapist, we alerted the deputy manager who directed staff on appropriate equipment to use.

Care plans contained conflicting and inconsistent information regarding the level of support people required to mobilise. For example, one person had experienced seven falls in recent weeks and although staff had accessed support from the community physiotherapist, their risk assessment and care plan had not been updated to reflect the equipment and staff support they now required when mobilising.

Some people who used the service had a risk of developing pressure damage but an assessment was not always completed to guide staff and where it had, this was not always updated when the person's needs had changed. On one occasion, a person's needs were identified as 'high' and required four hourly repositioning. However, records confirmed only weekly skin checks were being completed. The community nurse confirmed the person had not sustained pressure damage, but this heightened the risk of the person developing pressure related injuries.

We found there was a lack of risk assessment and guidance for staff relating to the risk of potential seizures for one person. The person had recently been admitted to hospital after having a seizure and during admission and discharge back to the home had experienced three more. There was no care plan in place to

direct staff on the safe care the person required including information they needed to help them recognise that a seizure may be about to occur and monitor accordingly.

This demonstrated a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to maintain and make available appropriate records that confirmed safe recruitment procedures had been followed. There were no recruitment records available for the acting manager, who had been recruited in January 2018 and left in March 2018. The regional manager confirmed these were held at head office and they would be provided, however we have not received this documentation.

The provider failed to maintain accurate and up to date staff records. This meant we were unable to check to ensure only people assessed as suitable to work in the caring profession were employed. The file for one new member of staff contained no written references. Another member of staff's application form showed gaps in their employment history which had not been discussed and recorded and only one written reference had been obtained. The files for three new members of staff did not contain a full Disclosure and Barring Service (DBS) check which would highlight any criminal record, although two members of staff had the DBS 'First check', which confirmed if they had been barred from practice. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

This demonstrated a breach in Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe in the home. However, there were mixed responses when we asked people if there were enough staff to assist them. Comments included, "Some girls work too much. I ring my bell and have to wait, they are short of staff", "Sometimes not enough, they could do with a few more" and "Look around, they [staff] don't stop and rarely have time to sit and chat with us or do any activities." Relatives we spoke with provided a mixed response, their comments included, "Yes, I'm always impressed with the level of staffing" and "No, it's clear they don't have enough on some days, the staff are running around and often there's no staff in the lounge area."

Since the last inspection there had been continued staff turnover and recruitment to fill vacancies had not kept pace with this. The operations manager confirmed there were vacancies for a manager, senior care and care workers, a cook, activities person and maintenance person. There had been many shifts when there were insufficient care staff on duty to provide the necessary care and support to people. All staff we spoke with confirmed there had been staff shortages and they had frequently struggled to manage people's care needs. They often felt overstretched on duty, worked excessive hours and regularly went without a break. Shortages of ancillary staff had meant care staff also covered these duties on shift, such as cooking and cleaning. The post of laundry assistant had been terminated and care staff now shared this role with the domestic staff.

The staff shortages had meant the provider had trialled moving people from the Devonshire Suite (where people living with dementia were cared for) to the main facility, so staff could be based in one area. But this had not been successful, as many people had felt upset and disorientated, needing additional support.

We saw staff were struggling to meet people's basic care needs. They were not deployed effectively to ensure that people were being provided with care and support in a consistent and planned way. This extended to all aspects of people's care and welfare needs including a lack of social activity and mental

stimulation. There were times when staff were not present in lounge areas to monitor people and provide appropriate levels of support. We observed verbal altercations between people on two occasions, when staff were not present and people were very upset and agitated. One person who required staff to monitor them at mealtimes to ensure they ate their meal safely was not observed as staff were too busy providing care to other people.

A dependency tool was used but this was not linked to the staffing tool and there was no management overview to ensure staffing levels were appropriate. The current levels in place were five staff in the morning, four on the late duty and three at night for 17 residents. Staff told us only three people could mobilise independently and most of the other people required the support of two staff. The regional manager told us they had recognised the staffing levels had needed to be increased and this had been done, however the rotas did not evidence any increase and they couldn't confirm when they had or intended to increase the staffing numbers.

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

The majority of staff had a good knowledge of procedures to follow if they suspected someone who used the service was at risk of abuse. One member of staff did not recognise the term 'safeguarding' and they had not had training in this subject, they were clear they would report any concerns about people to the acting manager, but there was a lack of awareness of the provider's whistleblowing policy or which external bodies to refer concerns to, such as the CQC. We saw safeguarding incidents had been referred to the local authority safeguarding team and notified to the CQC. In recent weeks, the safeguarding team had received a number of safeguarding concerns from external agencies and individuals. Some of which were being investigated by the safeguarding team and a number had been passed to the provider to complete an investigation and provide a report to the safeguarding team. We were informed prior to the inspection, that there had been delays with the provider completing the investigations and reports within the timescales set. We discussed these concerns with the regional manager who confirmed they were prioritising the completion of this work.

We looked at the maintenance records for the home. There were certificates showing fire systems and equipment, electrical systems, gas installations and lifting equipment were tested to ensure their safety at appropriate intervals. In addition the provider had records to show fire doors and systems such as window restrictors, water temperatures and emergency lighting were tested regularly. Accident and incident records were recorded and a new system to review and analyse these had been put in place.

Inadequate

Is the service effective?

Our findings

At our last inspection in November 2017, we found there were shortfalls and inconsistency with the application of mental capacity legislation and concluded this was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to inform us of the actions they would take to address our findings and make improvements. At this inspection, we found improvements had not been made and there had been deterioration in other areas.

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.

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. We found the provider was not always compliant with the MCA. Where people had restrictions in place such as bedrails and sensor beams or were receiving their medicines covertly, their capacity to make these decisions had not always been completed and the decision to provide them had not been discussed and recorded as in their best interest and as the least restrictive option. In discussions with staff, it was clear they had an understanding of the need for people to consent to care provided and we saw this in practise, however they had a poor understanding of the MCA.

Applications for DoLS had been submitted to the placing authority and one had been approved and seven were awaiting assessment. However, we had concerns that there were four people whom we felt should have been assessed to see if they met the criteria for a deprivation of liberty safeguard. They were accommodated in the Devonshire Suite and access/egress was via a key pad code. Staff told us these people did not have capacity to make decisions and some of their records contained records which supported this. Staff also said they would not be safe to leave the building on their own.

This demonstrated a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to health care services and received on-going health care support where required. However, they could not be assured that the guidance given by health care professionals would be followed, to ensure they received safe and effective care and support, in line with their current healthcare needs. For example, the use of correct moving and handling equipment and drinks given at the correct consistency as recommended by the SALT team. This has been mentioned in risk management in the 'Safe' domain.

We also had concerns regarding how some people's health care needs were met in a timely way. Some people, who were living with dementia, were unable to tell staff when they were in pain. Indicators of pain were not included within their care plans to help staff identify when pain relief might be needed. A pain assessment tool was not being used to enable staff to assess the pain levels of people living with dementia and the effectiveness of any pain relief that was given. From observations, records and discussions with community healthcare professionals we identified that two people's pain management was not effective and required review. We discussed these concerns with the senior care worker who contacted the person's GP to arrange this; however we were concerned this action had been prompted by the inspector and there could have been further delays for people in receiving the treatment they needed.

Where people were at risk of malnutrition and dehydration, risk assessments were not always in place or records completed to monitor people's weights. One person had lost weight in recent months and this had not been identified by staff or referred to community health professionals for advice. We asked the acting manager to follow this up during the inspection.

Some people's food and fluid intake was being recorded to monitor and evaluate their needs. However, these records were ineffective. There was no daily intake or output targets recorded on fluid charts to enable staff to evaluate people's needs. There was nothing documented within daily records to show that staff had recognised below average food and fluid intake or whether they had escalated their concerns to a senior member of staff when a person had eaten or drank a small amount. There was no accountability for checking and acting on the food and fluid information that was recorded. Whilst people were supported with their food and fluid needs, the systems in place to ensure people's needs were assessed and met was not effective.

This demonstrated a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were gaps in the staff training and supervision programmes. The staff training record showed some staff had not received training in areas which the provider considered essential such as safeguarding, infection prevention and control, food hygiene, dementia, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), fire safety, health and safety and first aid. The records showed that although some staff had completed the training, many of the courses were now out of date and staff required refresher sessions. When we discussed the gaps in the staff training programme with the acting manager they were unable to account for this and could provide no information or assurance that the outstanding training was scheduled.

There were a number of new staff working at the home who were not adequately trained or experienced and had received minimal induction training. Records showed the only training that two new staff (employed in November 2017 and February 2018) had received was moving and handling; one member of staff had also completed a course in dementia care and the other first aid training. Another new member of staff, recruited in January 2018 had only completed moving and handling and falls prevention training on the training record and there were no training certificates in their personnel file.

The regional manager told us five senior care staff had responsibilities for administering medicines. They had all completed medication training and four now required their annual update. There were no records to demonstrate these staff had their competency assessed in relation to administering medicines, although the deputy manager completed a competency assessment for one member of staff during the second day of the inspection.

There was a lack of staff supervision taking place. The acting manager had not received supervision since their employment in January 2018, although their role had changed from deputy manager. Another new staff member employed in November 2017 had attended one supervision meeting with their line manager. Most staff we spoke with told us they had not had opportunities to discuss their work role and responsibilities since before the registered manager left in October 2017. There was no programme of staff supervision in place.

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

Prior to the inspection we had been informed of concerns about limited choices and an over reliance on 'ready meals.' The meals served during the inspection were home cooked and people were provided with choice. In discussions with the cook, they confirmed menu choices had been limited on some days, but new menus were now in place, although we saw these had not yet been updated on the notice board. The cook had some understanding of special diets and received information about people's nutritional needs from care staff. Those people who required their meals to be textured or pureed were provided with meals of the appropriate consistency. We saw the cook made fortified milkshakes and provided a range of fortified snacks, such as homemade cakes.

We observed a poor breakfast experience on the first day of the inspection due to a lack of person-centred planning. A decision had been made by the acting manager, to support people to eat breakfast together in the dining room to improve their social experience, however due to the time taken to manage people's personal care support and the lack of organisation; this led to three people waiting two and half hours for their meal. We found improvements with the breakfast service the next day and people were supported with their meal as they got up. We observed staff supporting people to eat their meals in a sensitive way. People who used the service gave positive comments about the meals provided to them, these included, "Lovely meal, I've enjoyed every mouthful" and "I enjoy the roast chicken meals. I eat what I like, there's usually a choice. I wouldn't have tried some foods if I hadn't been here, such as chicken burger."

At the last inspection, we found areas of the service had been refurbished and redecorated and attention had been paid to a positive 'dementia friendly' design. The Devonshire Suite, where people living with dementia were supported, provided a responsive environment which supported people's orientation and sensory stimulation. At this inspection we found improvements to the environment had continued and the wet room on the ground floor had been completed and was now in use. Concerns had been raised before the inspection about the hot water supply to certain rooms. We found there was no hot water at the bath outlet in one bathroom and in the en-suite in a person's bedroom; we passed these concerns to the acting manager and the supply of water to those outlets was re-established during the inspection. The maintenance person confirmed further improvements were needed to increase the size of the water tanks, which the provider was looking into.

Requires Improvement

Is the service caring?

Our findings

We observed some staff practice that did not fully support and promote people's privacy and dignity. We observed two members of staff assisting two people on separate days of the inspection. On both occasions the staff experienced problems with the transfer and the person's clothing was disturbed in an undignified manner in a public area. We overheard staff openly refer to the task of supporting people to the toilet in a way that did not reflect good person-centred practice and we observed some staff were indiscreet when discussing people's personal care needs in communal areas.

Staff were observed to be inattentive of people's needs throughout the day. We observed two occasions when people drank or ate cold food and drink left on tables by other people. Staff failed to take action to provide a fresh drink or snack. We observed a person was trying to talk to their relative and at times their language was loud and repetitive. This upset another person in the room who made loud derogatory statements about them. Although a member of staff was sitting next to this person, there was a significant delay before they intervened and provided any support. Eventually they offered to assist the person to move somewhere quieter.

We observed one person was moved in their wheelchair from where they were sitting in the conservatory listening to their music, to sit in the lounge, even though they told the member of staff they wanted to stay where they were. The person's care plan described how important music was to the person and they liked to listen to singers such as Frank Sinatra. We observed the person remained in the lounge for the remainder of day, asleep or withdrawn.

This demonstrated a breach in Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We saw a range of information was provided in the entrance hall for people who used the service and visitors. This included the previous CQC inspection report, activities and how to make a complaint. We saw staff did not always keep people's personal information private and confidential. Daily records of people's care including health professional records, repositioning records and records of fluid and food intake were kept in an open box in the dining room on a table. We mentioned this to the regional manager to address.

During this inspection we observed staff interaction with people was predominantly task based. Staff had little time to chat to people other than when they were providing care and support. For example, in the main lounge there people were frequently left without staff support. People were either asleep or withdrawn, the television was on but people seemed disinterested in it and no interaction was taking place.

We received mixed feedback about staff from people we spoke with. One person said, "One or two of the older ones really are nice and very considerate; the new ones are not so good." Another person said, "On the whole they [staff] are lovely. They are kind but have to work too hard." A further person said, "Most of them [staff] are kind." Relatives we spoke with described the staff as kind and considerate. One relative commented, "We have the utmost respect for the staff and their welcome concern for [Name of family member's] complex needs."

People who chose to stay in their rooms told us staff always knocked on their doors before entering and this was confirmed from our observations. We observed caring interactions between staff and people who used the service, particularly during the medicines round.

People had chosen what they wanted to bring into the service to furnish their bedrooms. They had brought their ornaments and photographs of family and friends for their walls. This personalised their space and supported people to orientate themselves. We observed staff kept people's rooms tidy and respected their possessions.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the acting manager, staff, people and visitors demonstrated that discrimination was not a feature of the service. However, not all staff had undertaken training in equality and diversity and the provider's policies and procedures required updating.

People told us they were able to have visitors at any time and could see people in private. Visitors said they were always made welcome and although staff were busy they were always friendly and approachable.

Records showed people had received support from advocacy services. Advocates help to ensure that people's views and preferences are heard where they experience difficulty or are unable to articulate and express their own views.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2017, we found the care plans were not always person-centred and missed important information regarding how staff were to care for people. We concluded this was breach of Regulation 9 (Person- centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to inform us of the actions they would take to address our findings and make improvements. At this inspection, we found improvements had not been made and there had been deterioration in other areas.

The regional manager explained there had been delays with the implementation of the new computerised recording system and our review of the care records, showed minimal changes since the previous inspection. Care plans lacked important information to ensure people received care and support appropriate to their current assessed needs. The daily care records for one person admitted to the service in January 2018 showed they required regular support with personal care, behaviour management, medicines, nutrition, hydration and continence. There was no assessment completed and no care plans in place to guide staff in how to manage their needs in a person-centred way.

One person's care plans lacked full guidance in how to manage their behaviours which were challenging to staff. They did not provide staff with interventions to use about how to distract or engage positively with them. There was no profile information completed to provide staff with information about the person's personality, background and interests to inform their approach. Also, other people who had changing behaviours lacked a care plan to guide staff in how to manage them in a consistent way which was safe for the person and for staff. A community mental health nurse was visiting a person to assess how staff were managing their behaviour and agitation. The mental health nurse explained how they had directed staff to provide a structured daily programme of meaningful activity, but there was no evidence staff had developed.

Feedback from people identified that they were not receiving support with bathing or a shower in line with their preferences. One person told us they would prefer to have a bath once a week but they rarely had one. There were no records in their care file and a separate record held in the office showed the person had received support with bathing on one occasion in March 2018. This was the case for three other people's records we checked. Discussions with staff confirmed people were not receiving baths as often as they wished and the acting manager told us it was an area they knew they needed to improve.

We found care staff lacked knowledge about people's care plans. People's care plans were completed and reviewed by the senior care workers or other managers within the provider's organisation and were kept in the office. Although the regional manager said staff could access these at any time, we found that in practice they did not do so. As a result staff rarely, or not at all, read people's care records to understand their individual needs and preferences. One member of staff told us they had not read any care plans since they had started working at the home three weeks before.

We looked at how people's care was evaluated and found it had not been completed regularly. Senior care

workers commented on changes that had occurred, but this was not consistent and some evaluations missed reporting on incidents the previous month. The information in evaluations was also not always updated in the care plan so staff would have to read through evaluation records to see when changes had been made. Similarly advice and treatment from professional visitors such as physiotherapists and speech and language therapists was included in 'professional visitor's records' or letters following visits, but the information was not always added to the care plans. This meant there was a risk of updated information about care and treatment not being readily available to staff in care plans.

At this inspection the regional manager and staff confirmed that one person was deemed as requiring end of life care. On review of the person's care file we found their preferences and choices for their end of life care were not recorded. Their care records had not been updated since December 2017 and there was no care plan in place, which provided information detailing the person's pain management arrangements and the care to provide comfort and dignity for the person nearing the end of their life. The community palliative care team were visiting the person regularly each day. One of the team told us the person had been unsettled at the weekend, staff had not maintained records the person's bowel movements and the community palliative care team had required these to assess the person's care needs. We passed this on to the acting manager to address, who confirmed they would speak with staff and check the records were completed.

We found there were times when person-centred care had been inconsistent and staff had not been fully responsive to people's changing needs. For example, with one person's weight loss, another person's hydration support and two people's pain control.

We saw there was a lack of stimulation for people at Garden House. There was no activity coordinator in post and this was the case at the last inspection, which meant opportunities for people to take part in activities was limited as staff were engaged in providing care tasks. We asked people what activities they had access to. One person said, "No not really. My family visit most days and I have my TV." Other people told us, "No, there's not many activities and they never tell me until they are finished, so I miss them" and "I get very bored here, there is nothing to do whatsoever. We sleep a lot of the time."

On both days of the inspection there was a lack of activity provision and meaningful occupation for people. There was no activity programme and records showed few activities taking place. On the first day we observed one person completed a large piece jigsaw and on the second day another person played a game of badminton with a member of staff. There was also a visit from the PAT dog, which we saw people enjoyed. For the majority of time people in the home were not engaged in an activity. We saw people sitting in lounges for long periods of time without any social engagement. In one lounge, the television was on all day and people were not watching it. Some people's social needs had not been assessed and planned for. The regional manager described how they arranged for singers to visit. They told us, "We know there aren't any activities for people, we will recruit an activity coordinator."

We received mixed comments from people and relatives about their care. Comments included, "The staff who do the tablets are first class, but the new ones know nothing", "I've no problems with the care, there's just so little to occupy us", "I'm particularly pleased with the dementia staff and their understanding of [Name of family member's] needs."

This demonstrated a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did find some evidence of when staff had responded quickly to people's changing needs. For example,

staff had contacted emergency services and the crisis intervention team quickly for a person during a heighted anxiety episode. Staff had called emergency care practitioners when people sustained falls and skin tears and referred people to the falls team.

The provider had a complaints policy and procedure, a copy of which was displayed in the home. The complaints and concerns file was not available and this was the case at the last inspection. We found a complaint record in one person's care file. This had been received recently and managed in line with the provider's procedures. However, the senior management were not aware of these concerns which meant they were unavailable to evidence all complaints received and be assured they were informed of all shortfalls in the quality of the service.

People we spoke with and their relatives told us they knew how to make a complaint or raise concerns and would have no hesitation in making a formal complaint if the need arose. Comments included, "Yes, I'd speak with [Name of acting manager] and "I would talk to the senior or the manager."

Inadequate

Is the service well-led?

Our findings

At our last inspection in November 2017, we found the provider was not effectively monitoring the standard of the service provided and concluded this was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have found at this inspection that the provider had not completed the improvements they said they would and we have found continued breaches in Regulations 9, 11, 12 and 17 and new breaches in Regulations 10, 18 and 19.

There was a lack of managerial leadership and we had concerns with the overall governance of the service. There continued to be a turnover of managers. The registered manager had resigned and left the service in November 2017, they had only been in post nine months. A new acting manager had been recruited in January 2018 and had resigned two weeks before the inspection after being in post for 11 weeks. The deputy manager was employed in January 2018 and had been managing the service since the acting manager had left, with support from the regional manager. A new deputy manager had been appointed the week before the inspection.

Staff told us morale was very low and they were tired of the continued staffing changes and shortfalls they had experienced in recent months. Staff told us the new acting manager was very approachable and supportive and took action to try and make improvements.

The acting manager told us the director and the regional manager visited Garden House regularly, two or three times a week, this was confirmed in a discussion with the director and regional manager. However, there was no system in place to evidence the director or regional manager completed checks of the building, had oversight of audits and other records, spoke with people who used the service, relatives and staff or completed audits to assure themselves of the quality of the service provided to people.

We found the office and filing systems were disorganised, which had been the case at the last inspection. Throughout the inspection the management team experienced difficulties in accessing and finding records that were requested. Many records relating to the management of the regulated activity were missing and not available, such as staffing rotas, details of people who had died and complaints.

The new audit tools, procedures and risk management systems described in the action plan had not been set up and implemented. We found actions taken by the provider to make improvements were generally in response to concerns identified by external agencies such as North East Lincolnshire Clinical Commissioning Group (NELCCG) Procurement and Compliance Team, the Community Infection and Prevention and Control Nurse and Community Tissue Viability Nurse. However, there was no evidence to show that sustained improvements had been made within the service and following the recent suspension and breach of contract placed on the service by NEL CCG on 16 March 2018.

We saw there was no structured quality monitoring system in place that ensured identified shortfalls were addressed in a timely way and standards of service were maintained and improved. There were no records to demonstrate any actual audit checks had been completed on standards of hygiene, safeguarding

incidents, incidents of behaviour which challenged the service, weights, the environment, pressure damage, complaints and concerns, staff recruitment, training or staff supervision.

Effective audit systems were not in place to ensure people's needs were monitored and reviewed properly to inform their assessment and care planning. There were gaps in the weight records and no systems in place to identify if weight loss had been identified and appropriate referrals to the GP or dietician for assessment had been completed. An audit had been completed on medicines systems on 1 February 2018, the findings showed similar shortfalls that we had identified on the inspection and demonstrated that action had not been taken to make improvements. We found the provider and regional manager had a lack of oversight regarding staffing levels; the system to ensure sufficient staff were provided on shifts to meet people's individual needs were not effective.

The environmental health officer for NE Lincolnshire council had visited the service on 31 January 2018 and awarded the service the same two star rating (Improvement necessary) as their previous visit in July 2017. Shortfalls had been identified with safe food management. Audits of the kitchen to identify any shortfalls and drive improvements had not been completed.

We had concerns about effective recording within the service. There were significant deficits in recording the assessment and care plans for people. We found the recording of monitoring charts for fluid intake was confusing and inconsistent. Staff did not 'total up' intake and output and there was no optimum amount of fluid indicated for care staff to encourage people to aim for. There were gaps in the charts for monitoring food and fluid intake, weights, bathing, bowel motions and repositioning records.

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

We found a new audit format for accident and incidents had been implemented and completed for March 2018. This record included the number of accidents that had occurred and identified any themes or trends so action could be taken to reduce the risk. The audit showed referrals had been made to the community falls team for two people who had experienced a number of recent falls, so their mobility could be reviewed by health professionals.

The provider had failed to always notify us of certain important events as part of their registration with the CQC. These included the change in management arrangements and the deaths of three people. We are dealing with this matter outside of the inspection process.

This demonstrated breaches of Regulations 15 and 18 (Notice of change and Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

Despite the shortfalls detailed above, people and their relatives were positive about the management of the home. They had positive comments about the acting manager. One person said, [Name of acting manager] is lovely and I have met the deputy." Health professionals stated the acting manager was approachable. A relative told us, "The service is well-managed although I believe management staff turnover is evident" and another relative said, "On the whole we are pleased with the service."

Staff meetings had been held on 10 January and 16 February for day staff and the 6 March for night staff. Agenda items included staff sickness, rotas, training, records, communication, laundry, kitchen hygiene and discussions about the needs of specific people who use the service. Records showed the management acknowledged staff had worked additional shifts often at short notice.

A resident's meeting had been held on 26 February 2018 and records showed eight people had attended and discussions were held about meals, entertainment and the activities people would like to participate in. There was no evidence their suggestions had been addressed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured all service user's needs were assessed and had not designed care or treatment plans to ensure those needs were met in a person-centred way.

The enforcement action we took:

We have issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people's privacy and dignity was protected at all times.

The enforcement action we took:

We have issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not consistently acted in accordance with the Mental Capacity Act 2005 in relation to when service users were unable to give consent because they lacked capacity. Also they had not consulted with the local authority when there was the possibility four service users met the criteria for a deprivation of liberty safeguard

The enforcement action we took:

We have issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured care and treatment was provided in a safe way for service users by: -

	Assessing and doing all that is reasonably practicable to mitigate risk. The proper and safe management of medicines. Assessing the risk of and preventing, detecting and controlling the spread of infections. Working with other professionals when responsibility for care and treatment of service users is shared.

The enforcement action we took:

We have issued a notice of proposal to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure:- Adequate systems were in place to assess, monitor and improve the quality of the service delivered to people. Ensure there were contemporaneous and accurate records relating to service users.

The enforcement action we took:

We have issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured robust systems for the safe recruitment of staff

The enforcement action we took:

We have issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to: Ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet service users needs. Provide staff with appropriate support, training, professional development and supervision as necessary to enable staff to carry out the duties they are employed to perform.

The enforcement action we took:

We have issued a notice of proposal to cancel the provider's registration.