Caring Homes Healthcare Group Limited

# Belmont House Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This unannounced inspection took place on 29 September and 4 October 2016. The home was registered on 13 July 2016 this was the first inspection of this home. The inspection was brought forward because of the number of concerns about the quality of the service provided to people that the CQC had received from the London Borough of Sutton, Sutton Clinical Commissioning Group and on many occasions from relatives of people who use the service and anonymous callers.

Belmont House Nursing Home provides accommodation, personal and nursing care for up to 60 older people. There were 19 people using the service when we visited. The home is divided into three units, one on each of the three floors of the home. The ground floor is for people with nursing needs and the first floor accommodates people with dementia. The third floor was not being used at the time of our inspection.

The home had a registered manager but they were no longer in post at the time of the inspection and had not yet deregistered. There was a newly appointed manager who was registered with CQC at another home within the Caring Homes Health Care Group. They had submitted an application to CQC to register as the manager of Belmont House.

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

We found the provider did not have effective systems to assess, review and manage risks to ensure the safety of people. For example staff were not using the right lancing device to test for blood sugar levels increasing the risks of cross infection. Suction machines were not prepared and set so these could be used in an emergency, to clear a person's airway if they choked. These issues were addressed when we pointed them out but the provider's own systems had not identified those issues.

People's risk assessments and management plans were not always updated when their needs changed. Risk assessment for falls had not been updated after people had had falls. This meant people were not being adequately protected against further risks of falls. The provider had a strategy to manage falls but this was not disseminated within the home so staff were aware of this strategy to reduce the risks of falls. Staff did not fully understand how to operate the sensor mat that was linked to the call bell system so these could be used effectively, to help prevent falls.

The provider did not have suitable arrangements to protect people against the risks that can arise from the unsafe management of medicines. Among the concerns we found, we noted that the quantity of medicines were not always recorded when received into the home or carried forward to provide an audit trail about how medicines were managed. On a few occasions we could not correlate the amount of medicines in stock with what had been received and given; therefore we could not confirm people had received their medicines

as prescribed. On at least three occasions on one day staff had signed the MAR sheet that medicines had been given to people but we found the medicines were still in their blister packs.

People had personal emergency evacuation plans (PEEP) in their care records but we found that these had not been reviewed when their needs had changed.

Staff recruitment procedures were not safe. Records did not show a current photograph of the staff member and none of the records we looked at had a current criminal record check. There was no evidence of any assessment of their suitability to work with people who used the service.

People were not supported as well as they could have been by staff who were knowledgeable in understanding their needs because they did not receive appropriate training and support. Records and feedback from staff showed that staff were not receiving regular supervision, particularly when they had all newly started working at the home.

The provider had not followed processes to ensure that any restrictions on people's liberty were kept to a minimum and to demonstrate that where these restrictions needed to be in place that appropriate risk assessments were undertaken and best interests decisions were made. For example all the doors and lifts to other floors were locked and opened via a key pad system. The number to use to open the doors or lift were not displayed. All the doors to the garden and patio areas were alarmed. This meant that people who were able to could not move around the home freely.

People were not supported by caring staff, who respected their privacy and dignity. For example we heard of two incidents where staff did not respond to call bells at night in a timely manner and people were unable to receive the help they needed. We saw a person being assisted to the toilet in the main corridor and the actions of the staff did not help to maintain the person privacy and dignity.

The bedding we looked at in people's rooms was of a poor quality and several people told us they were cold in bed. None of the bedrooms we looked at had secondary window coverings, i.e. net curtains or similar, even though the rooms overlooked private housing and other bedroom windows. This lack of secondary window coverings did not help to maintain a person's privacy and dignity.

The provider had not ensured that people always receive care from staff of a gender of their choosing, even though this information had been recorded in their records.

Care plans had not been updated to take into account peoples changing needs. Staff said they had not received training on reviewing people's care plans. There was no proper care planning and monitoring around pain management to help alleviate people's pain.

The programme of activities the home hoped to offer had not started fully during our inspection. In the ground floor lounge the television was on for the majority of both days, the volume was not very loud which may have meant that people could see the screen but not hear the programme. We did not see any activities taking place on the first floor which is mainly for people with dementia. We however saw a party that staff had arranged to celebrate a special occasion for two people at the home.

The provider had a complaints policy and a procedure to respond to people's concerns and complaints. A number of complaints and concerns had been raised about the quality of the service since it opened in July 2016. We saw these had been acknowledged and were still being investigated by senior staff so they could respond appropriately to the complainants.

The provider did not have adequate quality assurance systems. They had expanded the home's occupancy and did not have systems to check if people's needs were being met and they were not effectively monitoring and taking action where areas for improvements were identified, to ensure the quality of the service was being sustained.

Food charts, fluid balance charts and turning charts were not completed properly to monitor people's health. The provider was therefore not maintaining adequate records to show that people were being cared for appropriately. People were therefore not protected against the risks that can arise if appropriate records about their care are not maintained.

The provider had appropriate processes to manage abuse and staff were aware of the action to take if they see or hear about alleged abuse to safeguard people.

The provider had arrangements to support people with their healthcare needs. There was a GP who visited the home weekly and links to health care professionals within the community that staff contacted if they needed advice about how to care and treat people.

During the inspection we saw that people appeared well cared for. They presented well, with clean and appropriate clothes for the weather.

We found seven of breaches of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014. These were in relation to person centred care, dignity and respect, need for consent, safe care and treatment, good governance, staffing and fit and proper persons employed.

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.

The provider did not have effective systems to assess, review and manage risks to ensure the safety of people.

People's risk assessments and management plans were not always updated when their needs changed. Risk assessment for falls had not been updated after people had had falls.

The provider did not have suitable arrangements to protect people against the risks from the unsafe management of medicines.

Staff recruitment procedures were not safe. Records did not show a current criminal record check. There was no assessment of their suitability to work with people who used the service.

The provider had suitable arrangements to help protect people against the risk of abuse.

At the time of the inspection there were enough staff to meet people's needs.

### Is the service effective?

**Requires Improvement**

The home was not always effective.

People were not supported as well as they could have been by staff who were knowledgeable in understanding their needs because they did not receive appropriate training and support.

The provider had not ensured that any restrictions on people's liberty were kept to a minimum and action taken to minimise the impact of these through appropriate assessments and the involvement of people or their relatives.

There were arrangements to support people with their healthcare needs.

### Is the service caring?

**Requires Improvement**

The home was not always caring.

People were not supported by caring staff, who respected their privacy and dignity. Staff did not respond to call bells at night in a timely manner and make sure people's privacy was always maintained when they supported them with personal care.

The provider had not fully considered people's privacy and comfort when equipping their bedrooms. The windows did not have adequate coverings to maintain people's privacy and dignity should they be in their room.

People preferences to how they receive care and about the gender of staff to provide personal care to them were not always respected.

People presented well and appeared well cared for with a good standard of personal care.

## Is the service responsive?

**Requires Improvement**

The home was not always responsive.

Care plans had not been updated to take into account people's changing needs. There was no proper care planning around pain management.

The provider had a programme of activities but it had not started fully during our inspection. We saw limited activities taking place in the home during our inspection.

The provider had a complaints policy and a procedure to respond to people's concerns and complaints. Complaints received had been acknowledged and were being investigated.

## Is the service well-led?

**Inadequate**

The home was not well led.

The provider did not have adequate quality assurance systems. The home had expanded its occupancy since it had opened but the provider did not have effective systems to check if the quality of the service was meeting people's needs and keeping pace with the number of people being admitted to the home.

The provider was not maintaining adequate records to show that people were being cared for appropriately. The lack of appropriate records meant that people were at risks of receiving inappropriate care.

There were some arrangements in place to support people and relatives to give feedback about the quality of the service.

# Belmont House 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. It had been brought forward after we had received a number of concerns about the quality of the service from the LB of Sutton, Sutton Clinical Commissioning Group (SCCG), relatives and anonymous sources.

This unannounced inspection took place on 29 September and 4 October 2016. It was carried out by one inspector and an inspection manager.

We reviewed the information we had about the service prior to our visit and we looked at notifications that the provider is legally required to send us about certain events such as serious injuries and deaths.

Prior to the inspection we spoke with representatives of the Sutton local authority safeguarding adults' team and the SCCG. We also spoke with four relatives who had concerns about the care their family member was receiving.

During the inspection we gathered information by speaking with 12 people living at Belmont House, eight relatives, the interim manager, the regional manager, the clinical lead, one of the activities co-ordinators and six members of staff. We also spoke with the visiting speech and language therapist.

We observed care and support in communal areas in an informal manner. We looked at six care records and five staff records and reviewed records relating to the management of the service.

Inadequate

# Is the service safe?

## Our findings

People we spoke with said "Staff are polite but they are always changing, it's not the same staff all the time." One person told us about an incident where they accidently cut themselves and staff were unable to find any first aid products to cover the cut. Six relatives we spoke with before and during the inspection expressed their views that people were not safe and well cared for at Belmont House. They told us about numerous falls their relatives had sustained and the action staff had taken. They described the staff actions as slow and unresponsive to their relative's needs.

We found that where people's blood sugar levels needed to be tested in cases where they had diabetes, the provider did not ensure that staff had suitable equipment to reduce the risk of the spread of infection. There were three people who needed their blood sugar to be tested. Staff used an item of equipment to draw a drop of blood (a lancing device) that was intended to be used by a person self-monitoring and not for professional use. This practice poses a serious risk of cross-infection and staff were not aware of the risks posed to people and themselves by sharing lancing devices made for individual use or by using these when they were not intended to be used by professionals. The staff addressed this issue on the second day of the inspection. However, the provider's own risk management systems were ineffective in identifying this concern so this could be addressed.

The provider had not considered the risks to people if they needed their airways to be cleared in an emergency. This might be in cases where they might not be well or were unable to clear their airways and prevent the risk of fluid going into the lungs. There were two suction machines in the home that could be used to clear people's airways. These were still in their boxes and not prepared and set up so these could be used in an emergency. Appropriate suction catheters were not available such as the ones required for oral suction to clear a person's airway to prevent choking. The suction machines were taken out of their boxes when we pointed this out to staff and they told us they would order appropriate catheters immediately.

People had individual risk assessments which looked at a range of risks they faced so these were identified and mitigated. These included falls risk assessment, risk assessments for pressure ulcers, malnutrition and choking. One person was assessed at high risk of falls and had sustained three falls. The risk assessment had not been fully reviewed and updated with additional measures to prevent further falls. One person's management plan for falls after they had sustained a serious injury following a fall was the same as the one prior to the falls and there was no action identified as to how future falls would be mitigated.

The provider had a strategy to manage falls and various flow charts to guide staff on the steps to take to support people at risk of falls. We asked about these on the second day of the inspection but they were not made available on the floors for staff to use. They could not also tell us the expected steps they were supposed to take to manage different levels of risks. One such flow chart was brought into use when we enquired about it, but another in terms of the expected actions to take in relation to the different levels of risks was not in place. This showed that whilst the provider may have a falls strategy this was not being appropriately implemented to ensure the safety of people.

Some people who were at high risk of falls had a sensor mat under the mattress which would alarm and alert staff if the person was trying to get up from their bed increasing the risks of them falling. The mat was connected to the call bell system of the home. We received mixed feedback from staff about the use of these mats. One feedback said that the mat does not work when the bedroom's door is open; a few staff thought it worked and some did not know. Another staff thought a light sensor would also set an alarm if people tried to walk in their rooms. The call bell/alarm system was an advanced system and was also connected to the door. Staff were not clear how the system worked, so they understood how to use it to support people at risk of falls. The manager agreed that the system was not very clear and all staff needed training about how it worked. She said she would arrange for this as soon as possible and we will continue to monitor this and will check on this at our next inspection. We also saw that pull cords to the alarm system in bathrooms and toilets were tied up and out of reach should someone fall on the floor. This meant that people might not be able to reach these to call for help if they had a fall. We spoke with the manager about this and they said they would ensure the pull cords were untied.

Risk assessments were not in place for people who were diabetic and there were no appropriate management plans with the signs and symptoms to observe when people might have high or low blood sugar levels so staff could take appropriate action to ensure the safety and welfare of the person. Another person who was on a medicine to thin the blood did not have a risk assessment in regards to managing the risk of excessive or uncontrolled bleeding and the action for staff to take to minimise the risk.

People's risk assessments and management plans were also not always updated when their needs changed. They had personal emergency evacuation plans (PEEP) in their care records. These were completed when they were admitted to the home but we found that these had not been reviewed when their needs changed. A person who needed assistance of two staff with their mobility had not had the PEEP updated. It still said they needed one person to mobilise. The manual handling risk assessment for the person also referred to one staff supporting the person to mobilise.

During the inspection we observed staff moving a person using a wheelchair but there were no foot rests in place and their feet were touching the floor. This practice could cause severe injury to people. The care staff said the person did not want the footrests. But on looking at their care plans we could not see a record that the person had made an informed decision or that a best interest decisions had been made not to use foot rests. We also saw the person might have been at increased risk of injury because of previous injuries and operations to their lower limbs.

Risks related to the safe administration of medicines were not assessed. One person needed their medicines crushed so these could be administered to the person via a feeding tube that had been inserted into their stomach. We asked for a risk assessment in regards to this but staff had not carried one out. There was no record that the GP and the pharmacist had been involved in assessing risks regarding the way the medicines were being administered for the person.

The provider did not have suitable arrangements to protect people against the risks that can arise from the unsafe management of medicines. We looked at the management of medicines on the first and second floor. We found that at times medicines administration records (MAR) sheets were signed even though medicines were not in stock for staff to administer these. There were at least three people who did not receive their medicines for teatime on one day of the current medicines cycle as staff had signed the MAR sheets but the medicines were still in their blister packs.

On one occasion, we observed that the member of staff administering medicines left the medicines with the person and did not wait to check that the person had taken their medicines before signing the MAR chart.

This is not accordance with guidance on the management of medicines.

Medicines were managed in the home in cycles of 28 days. We found that medicines were not always recorded when received from the pharmacy or carried forward from the previous medicines cycle. As a result it was not always possible to check whether people were receiving their medicines as prescribed. We found at least two instances where people's medicines were not carried forward from a previous medicines cycle. In four cases we found that the quantity of medicines was recorded when received or carried forward, but the amount in stock did not match the amount that should be in stock. This meant that people were not receiving their medicines as prescribed because the quantity of medicines remaining in stock was higher than what should have been in place. One of the medicines was used to thin the blood to prevent clots from forming. Not taking the medicines can have a severe effect on people's health and welfare.

Staff had received training on medicines but there was no evidence their competencies had been assessed. The interim manager told us additional training for nursing staff had been organised with the supplying pharmacy for the 11 October 2016 and we will check on this at our next inspection.

The home had not taken steps to mitigate the risks to people's health and safety as they moved around the premises. On the first day of our inspection we saw the electrical cupboard on the ground floor was unlocked which meant that a person could have opened the cupboard and be put at risk of electrocution. The sluice room on the first floor was also unlocked and a person could have been exposed to harm if they entered the room. On the second day we observed the sluice room and the electric cupboard on the ground floor were both unlocked. We spoke to the manager about this to emphasise how important it was to people's safety that doors were kept locked.

The serious concerns identified in the above paragraphs were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four staff's personnel files and saw that not all the necessary steps had been carried out before staff were employed. Records did not show a current photograph of the person and none of the records we looked at had a current criminal records check. Six of the eight previous employment references we looked at only stated the dates the person had been employed for and did not give an assessment of their suitability for the role they had applied for. One reference for a previous employment was not from an employer given on the applicant's application form as having worked there. There were no records to show that this matter had been explored with the employee. Only one staff file had details of the employee's next of kin and phone numbers to contact in an emergency. The lack of checks did not ensure people were cared for by staff suitable for the role. The above was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection the service had insufficient numbers of staff to care for and support people to meet their needs. We received feedback from many relatives and health and social care professionals about this. During the inspection seven relatives we spoke with commented about the lack of staff especially at weekends and in the evening and at night. We heard of times when people pressed their call bell but it went unanswered for up to 30 minutes, people not receiving their medicines on time because of the lack of adequate staff and people having to wait in the mornings for personal care. Relatives also told us about the lack of staff in the lounge areas and in the garden when the weather was good and people were outside. We heard of people still in bed at 10.30am who had not had any breakfast. We looked at the staff rotas during our inspection but these did not clearly show which staff had worked on some days or nights or whether agency staff had been used to complement the staff numbers. We however saw that there were three or four trained nurses on duty during our inspection and four care workers. There was a registered nurse at night

and the numbers of care staff had also been increased at night from three to four care workers to compensate for the layout of the home. The manager said staffing levels had been improved and staff numbers would be looked at taking into consideration the number of people living at the home and their needs.

We found that medicines were appropriately stored in the home and the conditions of storage were monitored to ensure medicines were safe to use. Controlled drugs were also being managed appropriately and regular checks were in place to check the quantity in stock. Where people were prescribed medicines to be given as required we saw that there were protocols in place to inform staff when to give the medicines.

The manual handling risk assessments for people were clear about the equipment to use for each person if they needed support with manual handing. We saw that people who needed a hoist for transfers had their own slings that were identified in their care records and kept in their rooms. These were provided in sizes suitable for the person according to their individual needs. If other items of equipment were required such as sliding sheets then these were also identified in the person's care records and were provided to each person for individual use.

The provider had appropriate arrangements to ensure the safety of people in the event of a fire, although people's emergency evacuation plans required review. The fire alarm was tested weekly and arrangements to conduct regular fire drills were in place. We saw that the service had contracts in place for the maintenance of equipment used in the home, including the fire extinguishers and emergency lighting.

The provider had policies and procedures and staff we spoke with were aware of their responsibilities to safeguard people from harm. They had completed training on safeguarding adults and were aware of the signs of possible abuse and the action to take if they come across abuse or allegations of abuse. Staff told us they would report any allegations or suspicions of abuse to the manager so they could take appropriate action. A number of safeguarding referrals about the service had been made by the management of the home, other agencies and relatives. The management of the home were working in collaboration with all agencies involved to appropriately investigate and respond to any allegations of abuse and negligence that had been made against the home.

Requires Improvement

# Is the service effective?

## Our findings

When the home opened in July 2016 there was a registered manager and a deputy manager in place. They were not in post at the time of the inspection and a manager from another home within the Caring Homes Healthcare Group has been appointed to manage the home.

People were not cared for by staff who received appropriate training and support. One person commented, "Staff don't always know what they are doing." A staff member told us "When you start you are meant to be supernumerary for two weeks, so you can complete your training and have two weeks to learn about the home and people. But that did not happen; you just have to start work." Another member of staff told us they did not have an induction programme when they started working so they became familiar with the provider's policies, procedures and records management system.

Although a training programme was in place, records showed not all of the 26 staff had completed the providers' recommended training programme. The interim manager told us the majority of the training was e-learning, which was completed on line via a computer. The training records showed only one person had completed the Care certificate. The Care certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

Only four staff had completed the emergency first aid at work training with a further 18 noted as not requiring this training. Only 11 staff had completed the people moving training, this is a practical classroom based training and 16 had completed the on line manual handling training. We spoke with the interim manager about the lack of completed training and they told us more face to face training had been organised.

Staff were not supported through one to one supervision in their roles. Records showed that in August 2016 only two staff received one to one supervision and in September nine of the 26 staff received supervision. Four staff we spoke with about supervision, told us they had not had formal supervision. One told us that it was so busy, that they did not have time to do supervision. There was some evidence that group supervision sessions had taken place but this did not include all staff. There were no records that team meetings had taken place since the home opened. The above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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. The provider had arrangements in place to assess people's capacity in regards to making specific decisions. We saw that people's capacity to consent to their care had been assessed. In one case a mental capacity assessment about agreeing to care had been carried out but the judgement made did not flow from the assessment. This was because the person was assessed as having capacity, despite not meeting two of the criteria necessary to determine whether a person had capacity.

We talked with staff about their understanding of consent and mental capacity. They all understood the need to get people's consent before providing care but one staff said they would talk to people's relatives if there was a decision to be made about the person's care. They were not clear that they should always talk with the person using the service first before involving others in best interest decisions. One set of care plans where a person had capacity had been discussed with the relatives and there was no evidence the person had been involved in drawing the care plan even if they had been assessed as having capacity to manage their own affairs.

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). We found a number of restrictions on people's liberty in place at the home. Staff had not recognised that some of these restrictions limited people's freedom and could have contributed to a deprivation of liberty. For example there were sensor mats that alerted staff should people move from their beds and there were alarms on the bedrooms doors so that should the doors be opened and the alarm activated, staff would be alerted to the person leaving their room.

There was also a device to monitor a person's movement in their room, should they be walking in their room, as a way of managing falls. Whilst the intentions of those forms of restraints were to ensure people's safety, staff had not considered that these were restraints and they had not either gained capacitated consent for these actions or assessed whether people might lack capacity in regards to these specific decisions. They had also not carried out risk assessments and had not involved relatives and others in making best interests decisions for the person where they were not able to give consent, in accordance with the MCA.

Many of the people at Belmont House were independent with some aspects of their care and mobility. But the provider had not ensured that any restrictions on people's liberty were kept to a minimum and considered people's capacity to make decisions. For example all the doors and lifts to other floors were locked and opened via a key pad system. The number to use to open the doors or lift were not displayed to enable people who had capacity, to open the doors. All the doors to the enclosed garden and patio areas were alarmed. This meant that people who were able to could not move around the home freely. The above paragraphs show that there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other cases where people were refusing care and wanted to leave the home, the staff had recognised that people were being deprived of their liberty and had made the relevant applications to the local authority for authorisations to deprive people of their liberty.

People's preferences and likes and dislikes in relation to food was recorded in their care plans. Staff explained that people could choose what they ate at breakfast time and the menu for lunch and dinner was shown to people the day before and then staff checked that people were still happy with what they had chosen. Although we did see that on day two of our inspection, two plates of food from the ground floor dining area were taken upstairs to the two people on the first floor, without the people being asked if they were still happy to have the meal they have previously chosen. We saw that alternative meals were available for people if they changed their mind on what they wanted to eat.

The dining room was welcoming and each table was set with cutlery, condiments and a table cloth. People could also choose to eat in their room, or in the dining room, there was also a private dining room if families wanted to share a meal with their relative. There were sufficient staff to help people with their meals if they required support. We saw that staff sat with people who needed support with their meals and took their

time to encourage and support them to eat.

Whilst overall people's and relative's feedback about their meals were positive, we also received some negative feedback, "The food is not always hot," "They [staff] ran out of puddings one day" and "There was no marmalade or jam for my toast at breakfast."

People were supported to have appropriate access to healthcare services. There was a GP practice attached to the home and a GP visited the home weekly to review people. Recent care records showed that people were also seen by a number of healthcare professionals. For example the speech and language therapist [SALT] team visited the home on the day of the inspection to assess a person and to provide advice on diet consistency to aid the person's food intake.

A number of relatives, health and social care professionals had raised a number of concerns about the ability of the staff to support people with their healthcare needs, prior to our inspection. For example one safeguarding alert had been raised about whether a person was referred to their doctor in a timely manner when they had sustained an injury. This case was on going. However at the time of the inspection there were various clinical leads working with the home to help improve standards and to help embed good practice in the day to care of people and in managing their healthcare needs.

Requires Improvement

# Is the service caring?

## Our findings

People were not supported by caring staff. People commented "They [staff] come into my room but don't talk to me," and "Staff are always very busy, they don't have time to talk to me." A relative said "Some staff are very committed but they are often short of staff especially at night and at the weekends." One relative said "We are happy our relative is here but there needs to be better organisation around the place."

During the inspection two relatives told us staff did not respond to call bells at night and their family members were unable to reach the toilet in time. We saw one person being assisted to the toilet in the main corridor and staff waiting outside. The staff member opened the door, sufficiently wide that the person was visible to anyone passing and called in, "You done yet?" When the person indicated they had not finished, the staff member shut the door and walked away, coming back a few minutes later. During this time although the door to the bathroom was closed it was not locked to help maintain the person's privacy.

We looked in one bedroom and saw there was no cover on the duvet although the bed was made as though ready to sleep in. We saw the bottom sheet was very thin and was on a rubber type mattress. The pillow cases were also of a thin stretchy material. We looked at another bedroom and saw the duvet cover was in place but also made of very thin material. The person whose room it was told us they were cold in bed and they didn't have a blanket to put over their bed. We also saw that although the room overlooked private housing with windows facing the bedroom there were no net curtains or similar at the window. We then looked in other bedrooms and saw that none of the rooms had a secondary curtain or similar to help maintain a person privacy and dignity.

We saw a staff member enter a person's bedroom while they were still in bed and partially covered. The staff member left the door open while they went away for several minutes. The person could be clearly seen by anyone passing in the corridor.

During the inspection, we overheard a person telling the manager they only wanted to receive care from staff of their same gender, female staff. We looked at this person's care plan and it was clearly stated that the person had expressed the preference that only female staff should assist them. We spoke with the manager who on looking at the staff rota saw the person had been assisted by male staff the previous evening. The manager stated they would ensure staff knew this person's request for only female staff. During the second day of inspection we looked to see if the care plans or daily notes had been updated with this request and they had not. We asked the manager about this and they said staff had been verbally informed.

The above show that the provider did not have effective arrangements to always promote people's comfort and privacy when they were in their own rooms and for staff to maintain a person's privacy and dignity while assisting them. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw that people presented as well dressed and clean and were wearing appropriate clothes for the weather. There was a hairdressing saloon in the home and we saw that all

people appeared well groomed. Men were appropriately shaven and also looked well cared for.

We noted that some staff had started to develop caring relationship with people by the way they engaged with them. We spent time observing how staff talked with and engage with people. We saw that most of the staff's engagements with people were appropriate. One member of staff was particularly praised by some people and their relatives about their positive attitude to caring and supporting people and the way they engaged with them.

We also saw staff remembering and supporting a couple to celebrate their wedding anniversary. There was a small party and a cake was made especially for the occasion. We saw people enjoying themselves celebrating this occasion.

Requires Improvement

# Is the service responsive?

## Our findings

There were risks that people might not receive the care they needed because of the lack of comprehensive, person centred care planning.

The provider had a preadmission assessment format that was used to assess the needs of people who were referred to the home for admission. These were completed appropriately in most cases, but there was at least one case where this had not been completed prior to the person being admitted. Once people were admitted to the home staff undertook a more detailed assessment of people's needs and developed care plans where people's needs had been identified to describe the action staff needed to take to care for people.

We found that care plans were not always personalised and had not been kept up to date to reflect people's changing needs. One person's care plan on pain had not been updated when their pain management medicine was changed and still referred to the old pain medicines regime they had been receiving. The care plan was also not clear about how to monitor the pain and effectiveness of the pain medicines and how the additional pain medicine was to be given in combination with the regular pain medicine should the person have pain in between the regular doses. We looked at another person's care plan and we also did not see a clear care plan about how to manage the person's pain and we did not see regular use of pain charts to monitor and assess the effectiveness of medicines taken.

Where a person had an elimination need, this was identified in their needs assessment and they had been prescribed laxatives. However, this was not reflected in their care plan. We also did not see that their elimination patterns were being monitored to determine the effectiveness of the laxatives. Two other people with similar needs did not also have a clear plan in place to monitor the elimination patterns, putting them at risk of further complications.

Where people had pressure ulcers or wounds, care plans were mostly in place to describe how to manage and treat the wounds. Photographs had also been taken to monitor the wounds. We found one case where a person had a pressure ulcer which had been identified for two weeks prior to our inspection. There were no care plans, photographs and other wound records to describe the wound care and to document the treatment of the wound.

There were advance care plans for people, but these had not always been fully completed. Some had been started but not completed. In four of the five care plans we looked at, we did not see any 'Do Not Attempt Resuscitation' (DNAR) forms that had been completed, even though some people had been in the home for more than two months. Having managed another care home where there was active care planning around end of life care, the manager agreed that these needed to be completed and this was due to staff not being confident in addressing those topics

The provider had a form that staff used to record the extent that relatives wanted to be involved in the care of the family members. Some wanted to be involved when there were changes, some  when the care plans

were reviewed monthly and others three monthly. We saw that relatives had signed most of the care plans to show they had been involved when these were drawn up and in completing the person's 'This is me' forms. We however saw that relatives had not always been involved in the review of care records when people's needs had changed.

We talked with the manager and the regional manager about care plans and they both agreed that the care plans needed a lot of work and needed to be reviewed so these accurately reflected people's needs.

People's care plans did not always reflect their assessment of needs. As a result they were at risk of inappropriate and unsafe care and treatment. For example one person needs assessment said they had 'bilateral hearing aids,' but their care plans said they had only one hearing aid. The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The care records contained a section called 'This is me' which was about the backgrounds and the life history of the person. This part of the care plans were well completed, but we did not always see how this translated into activities for people. This was because we did not see and feedback we received showed that there were not many social and recreational activities in the home.

The programme of activities the home hoped to offer had not started fully during our inspection. We saw on our first day an outside entertainer was holding a singing session which many people and their relatives were attending. On the second day a film was being shown in the cinema room, which several people attended. In the ground floor lounge the television was on for the majority of both days, the volume was not very loud which may have meant that people could see the screen but not hear the programme. Radios were playing in different parts of the home tuned to appropriate music stations.

We spoke with one of the two part time activity co-ordinators who said they had to order and buy the equipment they needed before they could start up an activities programme. They did tell us about the individual work they had been doing, for example they had spent time with one person helping them to sort out their clothes and arrange their wardrobe. They said it was a simple task but had made the person very happy. We did not see any activities taking place on the first floor which is mainly for people with dementia.

The provider stated on their website that there was a minibus to take people out. The feedback we received from staff and people and their relatives was that no people had yet been on an outing in the minibus. The manager told us the minibus was shared with another of the provider's care services and they now had a driver and could start to take people on outings.

People's diverse needs were to some extent addressed in their care records. People or their relatives were asked about their faith and cultural backgrounds and this information was recorded.

Some staff were familiar with people's needs, preferences and likes and dislikes. Staff were aware of people's backgrounds and used this wherever possible to help communicate with people. This added to staff understanding of how to meet people's needs.

The provider had a complaints policy and a procedure to respond to people's concerns and complaints. We were informed that the procedure was given to all new people to the service in a service users' guide which was made available in all people's rooms. We did not see a complaints procedure displayed in the home. We mentioned this to the manager and after checking, they said they would make arrangements for one to be displayed in the reception area of the home as soon as possible. The manager also told us that they had an open door policy and that people could approach them any time to raise concerns and that these would be

taken seriously and addressed.

A number of complaints and concerns had been raised about the quality of the service since the home opened in July 2016. We saw that these had been acknowledged and that some of the complaints were still being investigated by senior staff so they could respond appropriately to the complainants. Some relatives had not been confident that if they made a complaint this would be listened to and addressed by the provider, so they had also raised complaints with other agencies which were responsible for commissioning their care. Some had also approached the CQC to tell us their concerns about the quality of the service. This meant that people and relatives were aware of how to complain if they were dissatisfied with the quality of the service. The manager said that she was determined to address all the complaints that had been made and respond to people appropriately.

Inadequate

# Is the service well-led?

## Our findings

People were not always protected against the risks of unsafe or inappropriate care because the provider did not have effective quality assurance and governance arrangements.

The home opened in July 2016. To prepare for the opening new care staff were recruited and were sent to a sister home for training and induction. The regional manager told us there was a phased admission process to the home with five people to be admitted in July and another five people in August. However, 10 people were admitted in July and by the end of August there were 20 people in total admitted to the home, some with complex needs and living with dementia. This meant that more people were admitted to the home than the staff could cope with. Despite the fact that the home opened with a mixture of experienced staff and new staff, one experienced member of staff said that although the new staff had received training and an induction, most of the time they were working with unqualified staff who did not know how to care for people.

The result of this was that staff, some of whom had not worked in the care sector previously found it overwhelming to care for and support people who had complex needs in a care home where practices and processes had not become established and proper relationships had not been formed with other health and social care professionals in the area. Concerns raised by health and social care professionals and relatives of people using the service were specifically around the numbers of staff on duty and their skills and experiences to meet people's needs. A number of key members of staff also found it difficult to cope with the rapid development of the home and had agreed to be demoted or had left the home. A member of staff told us that the expansion of the home had been rushed and the manager at the time had been working hard to cope with the workload. Another member of staff said management staff wrote and reviewed care plans and the new staff did not do any care plans as they said they had not had the training to write care plans.

The provider's governance and quality assurance systems and processes were not always effective to identify and address the concerns we had found at the service when things started to go wrong. There was an indication that the provider had started to take note of the concerns being raised by various parties when they had started to raise concerns in August about the quality of the care and support people were receiving, but comprehensive and prompt remedial action had not been taken. This led to an escalation of the concerns in September. The Sutton Clinical Commissioning Group were so concerned that they had arranged for a nurse to spend three days a week in September to help improve the standard of care people were receiving and to up skill the nurses and care workers.

Where audits were carried out and action plans developed to address areas that had been identified as requiring improvements, action had not always been taken in a timely manner according to the action plans. The action plan for an infection control audit on 22 August stated antibacterial hand gels should be placed around the home and in the reception area. However antibacterial hand gels were not in place during our inspection. It also stated staff should wear their uniform and jewellery (apart from a wedding band) and nail varnish was not allowed. On the second day of our inspection we saw care workers wearing jewellery on their fingers and the manager told us about night staff not wearing the correct uniform.

The medicines audit of 24 September stated the medicines trolley must be organised, MAR records to be tidier, pain assessments needed and service users running out of stocks of drugs. Our findings in regards to the management of medicines during our inspection showed that many of the issues identified during those audits had not been addressed at the time of our inspection. For example there were gaps in signing when medicines were administered, the MAR were not being completed appropriately in that the amount of medicines received or carried forward was not recorded and issues identified were not being actioned in a timely manner.

There was a health and safety audit at the end of August 2016. A few actions had arose from that audits, but the issues we identified at this inspections such as unlocked sluice rooms, an unlocked electrical room and tied pull cords had not been identified. In addition it had not identified that staff did not all know how to operate the call bell alarm system to help keep people safe and that inappropriate lancing devices were being used to test blood sugar levels where people were diabetic. This meant that audit was also not as effective as it could have been.

Another consequence of the rapid development of the home, was that people's records were not completed in a timely and comprehensively manner. In addition to care records not being reviewed appropriately to reflect people's needs, we found that food charts, fluid balance charts and turning charts were not completed properly. The provider was therefore not maintaining adequate records to show that people were being cared for appropriately and to provide the necessary assurance that people were receiving enough food and drinks and were being turned regularly to prevent pressure ulcers from developing. One person's care plan for the prevention of pressure ulcers said they needed to be turned two hourly, we did not see that their turning charts was kept up to date to show that they were being turned accordingly. The above shows that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager had started in the home about a week prior to our inspection. She said she kept an 'open door' so people, relatives and staff could approach her to talk about their concerns. Staff had mixed feelings about the recent changes in the management of the home, but said they wanted the service to improve and were committed to make the home a better place for people using the service.

The provider had arrangements to seek people's views about the service. There was a feedback/comment book and 'We valued your opinion' questionnaires' in the reception area of the home for people, their relatives or others to give feedback about the service. People had been asked about the 'things that are going well' and 'things not going quite as well' and also for their suggestions or requests for changes or activities. We saw a summary of people's answers including five positive comments about the food being good, drinks always being available and helpful staff. There were also 13 comments on things that were not going so well, many of which we had picked up during our inspection. The new manager had an action plan for the home which covered the feedback received. They were keen to receive feedback from people to identify any areas that needed to be improved.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered person did not ensure that the care and treatment planned and delivered to service users was appropriate to meet their needs, and reflected their preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The registered person did not ensure that service users were treated with dignity and respect and did not ensure their privacy was maintained at all times.<br><br>Regulation 10 (1)(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered person did not ensure that care and treatment of service users was only provided with the consent of the relevant person and that where people did not have capacity that they acted in accordance with the Mental capacity Act 2005.<br><br>Regulation 11 (1)(3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 12 HSCA RA Regulations 2014 Safe |

| | |
|---|---|
| personal care<br><br>Treatment of disease, disorder or injury | care and treatment<br><br>The registered person did not ensure that care and treatment was always provided in a safe way for service users in that appropriate arrangements were not in place to identify and manage risks to people.<br><br>The registered person did not have appropriate arrangements for the safe management of medicines.<br><br>Regulation 12 (1)(2)(a)(b)(d)(e)(g)(h) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered person did not ensure that systems or processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided. They did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.<br><br>Regulation 17 (1)(2)(a)(c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The registered person did not ensure persons employed were of good character, have the qualifications, competence, skills and experience for the work to be performed by them, and be able to properly performing tasks which are intrinsic to the work for which they are employed. Recruitment procedures must be established and operated effectively. Information must be available about each person employed<br>Regulation 19 (1)(2)(3) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered person did not ensure that persons employed received appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform,<br><br>Regulation 18 (2)(a) |