Smallwood Homes Limited

Thelwall Grange Nursing Home

Inspection report

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Thelwall
Warrington
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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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced comprehensive inspection took place over several days; 22 October, 28 November and 2 December 2015 and 12 and 28 January 2016 as part of our on-going enforcement activity. As part of this process the registered provider completed an on-going action plan that was continually updated. As a consequence of this it was decided to keep the inspection process open and to undertake visits over a period of time to assess the actions taken.

We had previously completed an unannounced comprehensive inspection of this service on 3 July 2015, 3 September 2015, and 12 September 2105 and found the provider was failing to meet legal requirements.

This inspection was carried out to check that the registered provider was now meeting the legal requirements. We found that they had not made sufficient improvements in relation to person-centred

Summary of findings

care, need for consent, safe care and treatment, premises and equipment, supporting staff, fit and proper persons employed and good governance and remained in breach of these regulations.

The contracts monitoring team from Warrington Borough Council (WBC) and Warrington CCG are monitoring the home. This is the council's usual practice that is designed to ensure any improvements are sustained. The CQC are continuing to work with the council.

Thelwall Grange is registered to provide accommodation for up to 43 older people with personal or nursing care needs. Respite care is also offered. The home is situated within its own grounds in a rural location and has access to local amenities. There were 26 people living in the home at the time of our inspection.

One of the conditions of registration for the home was that it must have a registered manager. The service had not had a registered manager in post since September 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider voluntarily agreed not to accept admissions at the home following our last visit. The home has also been under an embargo [not allowed to admit new residents] from the Warrington Borough Council since our last visit in August and September 2105. Workers from Warrington Borough Council and the Warrington Care Commissioning Group with particular input from Warrington's care homes and contract monitoring teams have been supporting the home throughout this process to assist the provider to improve the quality of care given to people living at the home.

Care plans we looked at during the five days of the inspection did not contain up to date information

We found that the recording of checks on people and the recording of food and drinks given to people in their bedrooms were inaccurate and could not be relied on to effectively monitor how people's care needs were being met.

We found that issues raised at the last inspection in September 2015 with regard to safety of hot radiators and hot water temperatures had not been fully addressed. Some radiators were still hot to the touch and had no covers in place. Some water temperatures were too hot, leaving people at risk of scalding.

Risk assessments were not updated to ensure that people were kept safe.

References were not always in place to ensure people were suitable to support people living at the home.

Staff lacked knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and were unaware of which people living in the home were subject to DoLS so that they could support them with any restrictions in place. Care files looked at for people with DoLS in place with recommendations had not been updated to ensure that the recommendations were being carried out.

We had concerns about the skill mix and the level of experience of staff. There was no clinical lead at the service. There was also only one qualified nurse employed directly by the registered provider and there was no evidence of clinical supervision for this person so that they could be supported. Clinical supervision has been promoted as a method of ensuring safe and accountable practice in nursing.

There were no staff undertaking the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Induction and training for staff did not fully equip them to provide a good standard of care to people using the service.

The environment had not been updated to ensure people living with dementia could move around the home independently. Whilst the home appeared visually cleaner, there was a strong malodour on a number of days that we visited.

Some improvements had been made however issues found at this inspection had not been identified in the monitoring system in place.

Summary of findings

The registered provider had developed a new governance system to assess quality and monitor risk. Whilst some parts of this and the concept behind it was good, it was not fully functioning. This meant that issues were not picked up on and addressed in a timely way.

Notifications to CQC had not always been sent in a timely manner.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service is not safe.

Risk assessments were not up to date to ensure people were kept safe.

Some work had been complted however, the issues with regard to hot water and hot radiators being left uncovered was not resolved.

Staff recruitment was not robust to ensure the safety of people living in the home.

The home was cleaner, however, there were some malodours present

Is the service effective?

Inadequate

The service is not effective.

There was no member of staff currently delegated to carry out the role as clinical lead at the service.

There was also only one qualified nurse employed directly by the registered provider.

Staff had not received training in Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were unsure which people were subject to DoLS and what that meant for them in respect of how they cared for people.

The environment was not improved to ensure people living with dementia could move around the home independently.

Is the service caring?

Requires improvement

The service was not always caring

People were not always treated with dignity and respect.

Staff did not always engage with people in their bedrooms as they were busy and task orientated.

Individual staff were kind and patient with people and we saw some examples of good interactions between staff and people living in the home.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not always up to date to enable staff know the most recent care to be given.

Documents to record care, fluids and diet taken were not completed contemporaneously. This meant they were inaccurate and presented a false picture of the care that had been given to people.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

The service has not had a registered manager in place since September 2015.

Notifications were not always sent to CQC in a timely manner.

Quality assurance systems in place did not identify issues found at this inspection

Thelwall Grange 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.

We undertook a comprehensive inspection of Thelwall Grange Nursing Home on the 22 October 2015, 12 and 28 January 2016. A specialist pharmacy inspector These visits were unannounced.

The inspection was undertaken on the various days by one inspection manager, four adult social care inspectors and an enforcement lead inspector. A specialist advisor pharmacist visited the home on 27 November 2015 and a specialist advisor with regard to Mental Capacity Act and Deprivation of Liberty Safeguards accompanied us on 12 and 28 January 2016.

During our inspection we observed how the staff interacted with people who used the service, including during lunch. Some people were unable to speak with us directly because of communication needs relating to dementia. We used the Short Observational Framework for Inspection (SOFI). The SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the home, this included the provider's action plans, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with the acting manager, registered provider, quality assurance lead, looked at the care records for 17 people, staff training records, four staff personnel files, the quality assurance system in place which including checking of room temperatures and staffing rotas. We spoke with 16 people who live at the home, 4 relatives/friends and 16 members of staff.

Inadequate

Is the service safe?

Our findings

At our last inspection on 3 July 2015, 3 September 2015, 12 September 2105 we found that the provider was in breach of regulations relating to the environment, safe care and treatment and staffing.

At the last inspection we found that not all of the people living at Thelwall Grange had access to call bell systems. At this visit people living at Thelwall Grange told us they sometimes had to wait to be attended to. One person used a mobile phone to ring the home as their buzzer was not answered especially at night. The home had a call bell system which was linked to an an intercom which could be heard throughout the home. On several occasions it staff could be heard using this to locate each other and to inform people when they were "on their way. " Some people said that this could be heard when they were trying to rest in their rooms and felt that it disturbed their privacy. A "portable" door bell had been purchased to put on the arm of their chair if they were unable to reach the call bell. This door bell was linked to a unit which could be heard in the office.

We have been informed by Cheshire Fire Service who have completed an inspection of the home that they have successfully prosecuted the registered provider for failure to comply with fire regulations.

During the inspection on 12 January we carried out a tour of the home, checking the environment to assess its safety and suitability for people living at the home.

We found that issues raised at the last inspection in September 2015 with regard to safety of hot radiators and hot water temperatures had not been fully addressed. Some progress had been made but there were still some issues which needed attention and which left people using the service at risk of harm. We checked the water temperatures in communal bathrooms and in people's own bedrooms and en suite toilets. We also checked the temperature of radiators and whether they were guarded to ensure people could not burn themselves. We found that some radiators were still extremely hot to touch and would present a risk of scalding should a person come into contact with them. Several remained unguarded. The registered provider advised us that the radiator covers were being fitted in early February.

We also found that some water temperatures remained very hot (in excess of 55 degrees centigrade). No thermometers were provided in the communal bathrooms to enable staff to check the temperature of the bath water prior to immersing a person.

We found that there was no water supply at all to the hand wash basin in one person's bedroom and there was no hot water supply to one of the baths in the communal bathrooms because the tap was broken. Despite pointing out these issues on 12 January when we returned to complete our inspection on 28 January a number of these issues remained outstanding.

We were shown a record of water temperature checks completed by the maintenance person. However, these seemed inconsistent with our findings, were incomplete and had failed to identify that there was no water at all to one room and that one bath tap was not working.

We checked the fire escape doors and noted that one was difficult to shut fully once it had been opened. This was checked and rectified by the maintenance man at the time of the visit on 12 January 2016. Another was not alarmed to warn staff if someone living at the home exited through it. Given that a number of people living at the home are subject to Deprivation of Liberty Safeguards, this was concerning because they would be at severe risk of harm if they were able to leave the home unattended.

On the 12 January we noted that the home did look visibly cleaner. However, there was still a strong malodour in parts of the home. This was also apparent on 28 January; from the smell it was clear that air freshener had been used in copious quantities but it did not mask the underlying odour.

People living at Thelwall Grange told us they sometimes had to wait to be attended to. One person used a mobile phone to ring the home as their buzzer was not answered especially at night.

The above issues were a continued breach of Regulations 12 and 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014

The clutter observed around the home during the last by CQC and the fire service had been removed

We looked at how staff assessed and reduced risks to people living at the home. Since the last inspection the registered provider had introduced a system to analyse

Inadequate

Is the service safe?

accidents and incidents to identify any learning and help to improve the service. We noted that a good piece of work had been completed assessing the reasons why one person may have been falling. As a result staff had changed this person's footwear and reduced the number of falls this person had suffered. Although this was all written up in a file in the office, the details had not been written up into the person's own care notes, which would have been beneficial, to ensure all staff were aware of the changes.

We looked at a selection of care files to see how different risks had been identified and monitored.

Risk assessments in relation to the environment were not always in place. For example, we found that where water or radiators were too hot there were no risk assessments in place to assess or mitigate the risks to people using them.

We also found that in some cases, risk assessments had not been reviewed when people's care needs had changed. For example, the waterlow risk assessment (to determine the risk of skin damage due to pressure) for one person had not been reviewed and increased, even though some aspects of their care needs had changed. This meant that people were at risk of developing pressure sores. We asked a professional from the CCG to assess this person's pressure areas and were advised that they were intact, however , the lack of an accurate risk assessment and care plan put the person at higher risk of skin breakdown.

The above issues were a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014

The registered provider told us that staffing levels consisted of one nurse and 5 carers from 8am-8pm each day. There was also a cook on duty in the mornings until 2.30pm, a domestic from 9am – 3.30pm and a laundry worker from 8am – 2pm. One of the care staff went into the kitchen during the afternoon to finish any preparations for tea and to serve it.

Since our last visit there had been a staff member in the laundry each day and there were daily numbers of domestic staff to improve the service given to the people living in the home. We found that the laundry area was clean and well organised.

At the time of the inspection there were 24 people living at the home. Several people told us they liked living at the home but they did have to wait. Although staff numbers seemed adequate we found instances on 12 January where people did not receive the care they needed. This is discussed more fully in the effective section of this report.

We spoke with staff on duty and some were unaware of what safeguarding was and what action to take if they suspected abuse taking place. New staff had not received training with regard to safeguarding. This meant that people were at risk of harm and may not be fully protected if abuse was suspected or had occurred. Some notifications with regard to suspected abuse had been sent to CQC sometime after these had been reported to the local authority.We discussed this with the provider who stated that some issues reported to Warrington Borough Council as safeguarding had been referred to the provider to investigate therefore notifications had not been sent to CQC.

We were not receiving notifications with regard to other incidents in a timely manner.

Recruitment files kept at the service did not contain all the information required under schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Of the three files we looked at one person had only one testimonial from a family friend dated 16 June 2105. This person commenced work on 4 December 2105. The registered provider stated that a reference had been received and requested a copy of the reference for this person be forwarded to them on the day of our inspection. A further reference was sent to the registered provider on 28 January 2016, the date of our inspection. A second file had only one reference and the third file had no references in place. The registered provider stated that these references had been seen by a member of the management team and were lost on a computer. We could not be satisfied that staff had references and checks completed before starting work due to the lack of records available. Disclosure and Barring Service (DBS) background checks had been obtained prior to when the people had commenced work at the home. These checks help to ensure people were safe to work at the service.

The examples above were a breach of Regulation 19 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A specialist pharmacy inspector visited the home on 26 November 2015 and looked at all aspects of medicine

management. They found that the storage of medicines was generally good. The control drug cupboard was locked and contained appropriate medicines. The control drug register (CDs) appeared to be comprehensively completed. There was no routine check of CD quantities other than a count whenever a CD was administered. This was discussed with the registered provider and she stated that the introduction of a weekly CD check would be implemented. The home's Medicines Policy stated that CDs should be checked weekly.

Medicines for destruction were stored within the medicines' room and were well documented.

A spot check of ten Medicine Administration Records (MAR) charts was completed and it was found that all receipts of medications were documented apart from one.

One MAR chart gave concern as the allergy section of the chart stated 'Trimethoprim tablets' but the person had been receiving a 100mg dose of trimethoprim at night for over 2 weeks. The allergy section in the care plan was incomplete and therefore confusing. The person concerned had not suffered any ill effects from taking the medication.

Medication administration was observed for several residents. There was evidence of careful and considerate drug administration. Basic techniques were followed and the nurse was aware of key procedures. The nurse showed patience and had a caring rapport with the people living at the home. People were asked about the need for 'when required' treatments and outcomes well documented. Any omitted medicines were documented and explained. Medicines were stored in a drug trolley which was locked when left unattended.

There were no patients receiving self-medication and there was no use of 'Homely Remedies'. There were no medical gases on the premises.

Two people were receiving covert administration of medicines. In both cases there was documented evidence of approval from the GP both in their notes and on the MAR chart. However, there was no evidence that a pharmacist had been involved in the decision. A pharmacist should be involved to ensure the medicines are stable in the format they are being administered e.g. crushed, dissolved in a drink. This was discussed with the registered provider following our visit in September 2015.

Inadequate

Is the service effective?

Our findings

At our last inspection on 3 July 2015, 3 September 2015, 12 September 2105 we found that the provider was in breach of regulations relating to the need for consent, safe care and treatment, the environment and safeguarding.

People that we spoke with all said they liked the food provided at the home. Lunch on 12 January was pork casserole and boiled potatoes, which looked and smelled tasty. People said they were enjoying it. People who required a soft diet were served the individual components of the meal so that they could taste the separate parts of the meal. One person said "The staff help feed me. I think they are all nice" and another said "I think the food can be okay."A family member was feeding their relative and the person next to them. This person told us "The staff are fantastic and are so responsive to people's needs. I will sometimes help feed X at lunch time because the staff can be busy, it is better than it has been."

The registered provider has replaced the broken scales and people's weights are now being recorded. We saw that some people had been referred to the dietician however, we found that it had been recorded in one care plan that someone was losing weight and we found no evidence that they had been referred to a dietician or GP. One person had been referred to the dietician but we were informed by the registered provider that it could take up to 12 weeks for a visit to be arranged. We had concerns that staff at the home were not proactive enough in following up the referral and expediting a visit. This would have ensured that they got professional advice regarding how to manage this person's weight loss in a timely way.

Whilst there appeared to be adequate numbers of staff on duty we had concerns about the skill mix and the level of experience of staff. For example, on 12 January we saw that two members of care staff were working together. They were not in uniform and told us this was because they were both newly employed. Although the Quality Lead for the company was working in the home that day, he was working with another member of care staff who had been working there for longer. There appeared to be little supervision or direction of staff and throughout the morning we saw that some people were not receiving the care and attention they needed but this was not being identified by any senior member of staff within the home. For example one person who was unwell and being nursed in bed was left unattended for a number of hours and several people were left waiting to go to the toilet at lunch time. We overheard one resident say to another "you know you can't go when they are busy with lunch."

During our observation on 28 January we saw there were three care staff assisting people who live at the home with their lunch. Four people were sat at a dining table whilst other people were sat in chairs with small tables in front of them. Some of these tables were low and people were slumped in the chairs whilst trying to eat their meals One person was assisted with their meal however, we observed that two people kept falling asleep and staff had to keep waking them up to eat their food. One person refused their meal and a staff member sat with them for some time providing reassurance. It was observed that on occasions the staff were very busy and struggled to help assist the people who needed assistance with their meals. A family member was feeding their relative and the person next to them. The TV was on and nobody was watching this, this was very loud and could have possibly been turned down while people ate.

The issues highlighted above are a continued breach of Regulations 9,12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was no member of staff currently delegated to carry out the role as clinical lead at the service. There was also only one qualified nurse employed directly by the registered provider. This meant that there were no clinical staff with direct responsibility for delegated tasks such as the management of medicines, monitoring of people's nutrition and hydration needs, catheter care and wound management. There was no one within the service with responsibility for clinical supervision or designated to carry out checks on the clinical competencies of nursing staff. We were told and this was confirmed from rotas that all nursing staff were employed directly from nursing agencies and although the registered provider tried to ensure the same agency staff attended to provide consistency, staff told us at weekends there were often agency staff who had not worked at the home before. They told us this placed pressure on the permanent care staff who had to show the person what to do.

We were therefore not assured that there were sufficient skilled staff, available to provide the care and support that people needed. Prior to our inspection we received information of concern from health care professionals who

told us that on occasions they found agency nursing staff who did not have the required skills and knowledge to meet the needs of people with indwelling catheters. For example, community nursing staff were told on occasions that there was nobody on duty to deal with a blocked catheter, a fundamental nursing skill.

We saw records of supervision for care staff working at the home however, there was no evidence of clinical supervision for the RGN who was employed by the home. Clinical supervision has been promoted as a method of ensuring safe and accountable practice in nursing. This was discussed with the registered provider at the last inspection visit In September 2015. The registered provider had completed a "managerial supervision" for the RGN but as she is not a nurse clinical supervision had not taken place.

We spoke with some staff about the training they received. One carer told us that when they started working at the home they had been given an information pack for reading, and had been able to shadow more experienced staff until they felt confident to work alone.

The registered provider told us training on safe working practices such as fire safety, safeguarding infection control and food hygiene was delivered in house. The lead manager for Smallwood Homes led work groups where staff watched a DVD, had a discussion and completed questionnaires. The registered provider confirmed the questionnaires were not sent to any external organisation to be checked. Some external training had been accessed such as fire safety and infection control. We found that only four staff members had received training with regard to Mental Capacity Act and Deprivation of Liberty Safeguards. This information had been provided in the form of a training matrix by the registered provider.

The registered provider told us that no staff were undertaking the Care Certificate training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

This was a continued breach of Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were informed by the registered provider that the lead manager for Smallwood homes was a trained moving and handling co-ordinator. This person was in the process of being assessed by Warrington Borough Council (WBC) as to their competencies to give this training. It had been advised by WBC that an education certificate be sourced to improve the training and advice as to extra good practice legislation to be included within the training given such as :- Health and Safety and Person Centred), Risk Assessment, Spinal Awareness and Controversial techniques. It was also advised that staff should sign to say this information has been given to them.

We saw completed induction checklists for two staff who had recently been employed which included an orientation to the home, health and safety, fire safety and other topics such as infection control and safeguarding. We saw that these checklists had been signed on the same day as the person commenced work at the home. A workbook was then given to the staff member to complete.

As part of the inspection process a specialist advisor with regard to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) was part of the team in January 2016.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. If someone is subject to continuous supervision and control and not free to leave they may be subject to a deprivation of liberty.

Care files looked at for people with DoLS in place with recommendations had not been updated to ensure that the recommendations were being carried out. Care files were basic with no signature from either the person or their family and there was no evidence to show that the family or the person living at the home had any input in the plans of care. Evaluations were very repetitive and did not give good information with regard to what had happened during the time between evaluations. Information is some care plans was confusing, for example, one file stated in one part that the person did not have a diagnosis of dementia, but in another part of the file it recorded that they did have dementia.

Risk assessments in place for one person with regard to falls and leaving the home lacked detailed input into what could happen and how the staff were to react to keep the

person safe. Care files looked at did not provide detailed risk assessments to provide staff with knowledge should a risk happen to the client while they were being cared for in a particular situation, for example bathing or walking.

We saw an assessment form in care plans with regard to assessing the capacity of people who live at the home. People who are living with dementia and are unable to make decisions have now been assessed and have DoLs in place if this is appropriate. However, the DoLS checklist used by the home for one person recorded conflicting views.. For example, assessments completed from March 2015 to August 2015 recorded that the person "has capacity but their memory is deteriorating." Assessments dated September 2015 to December 2015 recorded that they "have full capacity" and there was no mention of memory loss. The assessment dated December 2015 to January 2016 recorded again that the person "has capacity but their memory is deteriorating."

Staff had not received training to understand and use these in practice and did not completely understand how DoLS affected the people living at the service. Staff told us they were unsure if anyone at the service had a DoLS authorisation in place, when in fact some people living at the service had DoLS authorisations in place. The staff were unable to describe their responsibilities in supporting people to make decisions or in seeking advice when people were unable to do so.

The registered provider showed us a white board in the office which indicated which people were subject to DoLS.

On the 28 January a Best Interest Assessor (BIA) was visiting the home. She later expressed some concerns to CQC regarding the understanding of the registered provider around the Mental Capacity Act and DoLS. Applications for DoLS authorisations appeared to have been made for people living at the home who actually had the capacity to make decisions or themselves.

This is a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) 2014

Although the home had undergone some painting we found that no improvements had been made within the environment for people living with dementia. We found communal areas had been painted the same neutral colour scheme throughout, and that toilet doors were painted the same colour as people's bedroom doors. There was some pictorial signage to the hairdressers and toilet in one lounge to provide a pictorial prompt to enable people to navigate themselves around the building. However, this was not consistently availiable throughout the home. This meant that people living with dementia were unable to recognise familiar locations, such as a toilet, bathroom or bedroom. This issue was raised with the registered provider at the last inspection in September 2015.

Requires improvement

Is the service caring?

Our findings

At our last inspection on 3 July 2015, 3 September 2015, 12 September 2105 we found that the provider was in breach of the regulation relating to dignity and respect.

We spoke with people who live at Thelwall Grange and they told us “They care for you here, I haven’t been so well but they keep an eye on me.” and “They (staff) are okay here. I don’t tend to leave my room much, I like my room.” One person told us that staff were getting deep pink paint for her so she could have one of the walls in her room painted to match her bedding. One relative said “ I have no complaints and X likes it here” Another said “the care staff do an amazing job in looking after him and provide excellent care”.

During the inspection we observed a number of people in bed during the day and a lack of staff going into their room to chat and only when needing to deal with personal care tasks. Staff were observed knocking on doors. The majority of interactions observed were task focussed such as assisting people to mobilise or when serving meals.

There were examples that we saw throughout the day that showed staff did not always engage with people in a way which had a positive impact on them. Care staff were not able to spend any other time with people than the time needed to complete the task they were required to perform. For example, a number of staff were witnessed walking through the lounge and connecting dining room without acknowledging people sitting there because they were busy completing the task they were focussed on. Care staff at times walked past without engaging with people or trying to initiate any conversation, especially as people were not occupied in any other activity. We saw people were left for long periods in both lounges without any staff support. During these times, people were unable to occupy themselves.

When staff did speak to people it was done in a respectful caring way. Staff who had been working at the home for some time knew people and their needs well however newer staff were unsure of how people were to be fully supported. Care staff told us that they did not “have anything to do with care plans”.

Televisions were on in both lounges with the volume very loud. The channel selected by a member of staff was also inappropriate as the daytime television programme shown people arguing, shouting and screaming. This did not contribute to a relaxing or therapeutic environment.

People were not always supported to maintain their dignity with regard to their personal care. For example during the inspection on 12 January we saw that one person was wearing a jumper stained with food. We checked several hours later and although care staff had just attended to this person they had failed to identify that their jumper needed changing.

We saw that on occasion people living in the home were referred to in their records in a less than respectful way, using judgemental phrases such as “X can be quite selfish”.

This is a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our last inspection on 3 July 2015, 3 September 2015, 12 September 2105 we found that the provider was in breach of the regulations relating to person centred care and safe care and treatment.

We looked at the care files for a number of people, where we identified concerns about the care they were receiving. We saw that one person's needs had changed significantly regarding their continence care. However, their care plans and risk assessments had not been updated to reflect this and their daily notes indicated that their skin was becoming sore. We highlighted this to the owner of the home on 12 January and involved other healthcare professionals who were able to confirm the person's skin integrity was satisfactory. However, when we returned on 28 January to complete our inspection, the person's needs in respect of continence had changed again and the care plan and risk assessment had still not been updated. Inaccurate and out of date care plans and risk assessments put people at risk of not receiving care that meets their needs.

Throughout the day on 12 January up until 1.40pm we kept checking on one person who was poorly and being nursed in bed. We checked this person's care file and saw that there was no short term care plan in place to instruct staff in the care for this person whilst they were acutely ill. We saw that this person remained in the same position all morning and was not offered anything to eat or drink. On the bedside table we saw there was a grease smeared glass, a quarter filled with water. This glass was present on every occasion we visited the room and the person had made no attempts to drink any of the remaining water.

We also saw another person who was being nursed in bed that morning because she was feeling unwell. At 11am we saw that they had a full beaker of cold coffee and a full beaker of juice on their bedside table, which they had not attempted to drink.

In the care plans we saw that many of the people were identified as requiring checks every 30 minutes to ensure their safety. In addition a number of people required monitoring regarding the food and fluids they were taking and in respect of changing their position to alleviate pressure. At 3.30pm we saw that one of the care staff was writing up all the daily monitoring charts from 8am that morning and recording regular 30 minute checks and lots of other details such as the amounts of fluids people had taken and at what time.

We asked the carer how they could remember all the details for everyone they had cared for all day up until that point. They replied that the times probably were not quite accurate but that they could remember what care had been given to everyone. However, we saw from our own observations that the records were completely inaccurate in respect of what fluids and diet people had taken and at what times. This was discussed with the management team on the day of our visit as this was the same situation that we found at our last visit in July/September 2015.

When we looked at the chart for the person who had two full drinks still on her bedside table at 11am, it was recorded that she had taken those drinks at 8am and 9.40am. We looked at the care plan for this person relating to their nutritional needs. This plan stated that the person should be weighed weekly and provided with a fortified diet. On the 7/1/15 the plan had been reviewed and a note added to instruct staff to offer higher calories and Complan to stabilise recent weight loss. The record of this person's weight showed that they had been weighed on 3/12/15 and not again until 9/1/16 when they had lost a further 4.4kgs in weight. A note in their file stated that they were to be referred to the dietician. When we asked the registered provider if this had been done she told us that a referral had been made via the GP but to date the dietician had not visited. Although we were told that there was a 12 week wait for dietician referrals, we were concerned that no attempt had been made to follow this up in view of the person's low weight.

When we checked the monitoring chart at 5.30pm for the person who was unattended until at least 1.40pm it had no entries on it from 8.50am. We highlighted these issues to the provider because inaccurate monitoring makes it impossible to effectively review what care has been given and whether it is meeting people's needs. In addition inaccurate monitoring means that serious issues such as people becoming dehydrated may not be identified because the records show that people have had more to drink than they actually have. Records on food and fluid intake must be legible, accurate, and specific and should the desired amount of intake not be achieved then this should prompt staff to encourage drinks and food.

Inadequate

Is the service responsive?

The issues highlighted above are a continued breach of Regulations 9,12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

When we returned to the home on 28 January we saw that a short term care plan had been written for this person to instruct staff on the care they needed to give. Monitoring charts had much improved for this person and it was clear that on that day this person had been attended to and given the care they needed. The registered provider told us that they had changed their procedure for updating the monitoring charts for people that were being nursed in bed and charts were being kept in people's rooms so that care interventions could be recorded contemporaneously.

An activities organiser was employed at the home 3 days a week. We saw the activities organiser going round to all the people living in the home during the morning of 12 January, giving some people their daily newspaper and chatting with others about what they would like to do that day. However, on the 28 January the activities organiser was not on duty and there was doubt amongst people as to whether they would get their morning paper. One person told us, "I like reading the newspaper, but if the activity chap isn't here I don't get one."

Some people told us they enjoyed reading and one person said they liked painting and staff were arranging to get more painting materials for him to pursue this interest. Several people mentioned that they sometimes played dominoes. One person told us the home was very isolated, so although they were able to go out independently, this cost them a lot in taxi fares. We saw that on all the occasions we visited the television was on in the lounge, although no one appeared to be watching it. Activities promoted were not always reflective of people's individual interests and hobbies.

Inadequate

Is the service well-led?

Our findings

At our previous inspections in July, and September 2015 we found a regulatory breach in relation to good governance as there was a lack of effective quality assurance systems in place to ensure continuous improvement of the service.

At this inspection we found the service was not well-led. The home did not have a registered manager. The registered manager left in September 2015. During our visit in October 2015 the home had appointed an acting manager whose skills, knowledge and experience were not suitable for them to adequately manage the home. The scale of the task and lack of permanent nursing staff had a significant impact on the progress made and the quality of service provided. The registered provider has now taken the role of day to day management of the home.

We found during all our visits that there was a lack of clinical governance. The registered provider was not a trained nurse and there was no clinical lead at the home. There was one permanent RGN employed by the home and the rest of the shifts were covered by agency staff. Although the registered provider tried to ensure consistency by requesting regular agency nurses we found that the agency nurses were not taking accountability to complete many of the tasks the nurses would normally carry out such as updating care plans and risk assessments.

The registered provider has over recent months put a lot of effort into developing better systems for identifying and monitoring risks and the quality of the service. Many of these systems were not yet fully embedded and by the registered provider's own admission it was too early for them to effectively identify themes or trends as part of a cycle of continuous improvement.

Some improvements had been made, for example in how accidents and incidents were being analysed. However, we still had concerns that the systems in place were failing to identify issues such as incomplete or missing care plans and inaccurate monitoring of people's care.

We looked at the care plan audit file and saw that a small number of care files had been audited and that a programme to audit them had been commenced with different staff allocated to review a certain number. However, we saw several audits that were carried out 24/12/15 with actions stating as being required by 24/1/16. When we checked these care files we could see that the actions remained outstanding on 28/1/16. We discussed this with the registered provider and highlighted that although we had advised that one person's care plan and risk assessments needed reviewing on 12/1/16, this had still not been done on 28/1/16. The registered provider told us that this was because they were working their way through all the files and hadn't got to that one yet. We advised that care plans and risk assessments need to be updated as soon as people's needs changed, so that staff had accurate information to work with.

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

Furthermore, it was apparent that all of the system was very much being driven by the registered provider and we could not see who, in their absence was competent and able to effectively manage the home in their absence. Although the registered provider advised us that a person has been recruited, that they hope will be suitable to register as the manager, a start date has yet to be confirmed and there is no guarantee that they will at this stage be registered as the manager.

We asked a number of people living at the home who was "in charge". We received a number of different answers and could see that no one was properly informed regarding the management arrangements of the home. We asked one person if they were asked for their opinion about whether their needs were being met and they said no feedback had been asked for from them. They went on to say "I could complain but there isn't any use because I know they haven't got any staff to remedy things."

Despite previous discussions regarding the submission of notifications, we found that the provider was still failing to notify the Commission in a timely way.