Smallwood Homes Limited

Cale Green Nursing Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection to this location.

There was a registered manager in place.

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

Cale Green Nursing Home is registered to provide nursing and residential care and for up to 50 people. The home is situated in Stockport, Greater Manchester. Accommodation is on two floors which could be accessed via 3 stair cases, including stair lift facilities and a passenger lift. All but three of the bedrooms were single occupancy. There were 3 communal areas, an outside balcony upstairs, and a hairdressing facility used to support people spending time together. The kitchen and laundry were located on the ground floor. There was a small garden to the rear of the property and off road car

Summary of findings

park at the front and rear. There were 45 people living at the home at the time of our inspection. The service met the regulations we inspected at our last inspection on 12 August 2014.

People using the service spoke warmly about the health care assistants (HCA's). We saw that relationship between people and the HCA's was good and people's care was provided with kindness.

Whilst people told us they felt safe we found people's safety was compromised. Pre-employment checks such as were not being completed before nurses started work to make sure they were suitable to work in the home.

We found there were not enough trained nurses on duty to meet people's nursing care needs and more recently there were no registered nurses working at the home for four consecutive days in April 2015.

We found that two nurses did not have valid and up to date registration with the Nursing and Midwifery Council (NMC). This meant that people using the service were not protected against the risk of unsafe or inappropriate nursing care and treatment.

Documents relating to the health, safety and welfare of people using the service had not been completed by people with the qualifications, skills, competence and experience to do so. This meant that people were at risk of receiving unsafe or inappropriate nursing care and treatment because the provider did not employ fit and proper staff who were able to provide care and treatment appropriate to their role.

Not all of the care plans seen showed that significant information about people's health status had been included in their care plan and people's health care was not accessed in a timely way.

All of the care files we looked at contained incomplete records which had not been signed or dated by the staff at the home.

Audit information to target improvement in areas such as care plans, people's weight, food and fluid intake and falls prevention were not in place.

People were not kept safe from the risk of harm from unregistered nursing staff who had not received up to date training in medicines handling and administration.

Following a recent investigation into medicine errors at the home, actions had been taken to improve how medicines were managed, however, not enough staff had been trained to administer medicines to people during the day.

Poor infection control practices resulting in dirty bed frames, furniture and under beds meant that people were not protected from the risk of cross infection.

We saw that some mattresses, pressure cushions and waterproof covers were dirty, ripped, heavily stained, not fit for purpose and did not help to increase comfort or relieve pressure. This meant that people were not protected against the risk of infection and developing pressure ulcers.

Systems in place to check and respond to environmental risks were not effective which meant health and safety issues were not always addressed.

Quality assurance systems in place were ineffective and did not support the management of the home in identifying where improvements were needed.

There was a lack of meaningful activities for people and there was no recent feedback available from people and their relatives about the quality of the care provided at the home.

We found systems in the home were disorganised and the lack of good communication systems meant that staff were not always clear about what was happening in the home.

We found significant breaches of regulation to the care and service provided to people and the home's internal quality assurance systems had failed identify them.

Following the inspection we contacted the local authority infection prevention and control team, the local authority adult safeguarding team and quality assurance team to share our concerns about the service.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (CQC) is considering the appropriate regulatory response to address the breaches.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by the CQC. The purpose of special measures is to:

Summary of findings

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again in six months

If insufficient improvements have been made such that there remains 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 the service.

This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the providers registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Nurses working at the home had been recruited without having valid up to date registration with the Nursing and Midwifery Council, which meant that nursing care was not available at all times to people who needed it and people were at significant risk of receiving inappropriate, unsafe care and treatment.

There were not enough trained nurses on duty to meet people's nursing care needs and there were no registered nurses working at the home for four consecutive days in April 2015.

Environmental and hygiene risks were not identified or managed in a timely way which put people at risk of harm from cross infection.

Is the service effective?

Inadequate

The service was not effective.

Nurses whose nurse registration had lapsed did not have essential up to date nursing competencies in place required to maintain effective care and treatment.

Access to external health care was not always sought in a timely way.

Staff supervision and appraisal was infrequent and future supervision dates had not been planned to make sure staff were regularly supported in their work.

Is the service caring?

Requires Improvement

The service was not caring.

Unregistered nurses and the registered manager had written nursing care plans for nursing resident's, carried out nursing assessments and evaluated the nursing care of 28 people at the home. This meant people were at risk of receiving inappropriate and unsafe nursing care.

Some care practices showed a lack of respect for people and undermined their dignity and independence.

We saw some staff interactions were warm and friendly towards people who used the service.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not up to date and did not provide staff with the information they required to meet people's nursing needs.

Summary of findings

The lack of skill, knowledge and training around safe and appropriate skin integrity care meant that people were at risk of developing pressure ulcers

People's preferences about the way they spent their time and the activities that were offered to them was not considered in a person centred way.

Is the service well-led?

The service was not well-led

Health care audits were not carried our regularly to help make sure that written instructions about people's health and wellbeing was up to date.

Managers and nurses working at the home were unclear about their roles and the systems used in the home because there was a lack of consistent leadership and communication systems were ineffective.

People were not protected because the provider did not have effective systems in place to monitor and assess the quality of the service provided.

Inadequate

Cale Green Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 April 2015 and first day was unannounced. We returned to the home on the 29 April to provide inspection feedback to the registered manager and to check there was a registered general nurse (RGN) working at the home.

The inspection was carried out by two inspectors, one expert by experience (ex by ex) and one specialist advisor (SPA). Experts and SPA's provide specialist advice and input into the Care Quality Commission's (CQC) regulatory inspection and investigation activity to ensure that CQC's judgements are informed by up to date and clinical and professional knowledge and experience.

Before we visited the home we checked information that we held about the service and the service provider. The provider completed a Provider Information Return (PIR) before the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR which included incident notifications they had sent us.

Since we completed our last inspection CQC had received a number of concerns about the service. We shared these concerns with the local authority (LA) adult safeguarding team.

Some of the people living at the home were unable to give their verbal opinion about the care and support they received therefore we used a short observational framework for inspection (SOFI). This is a tool used by the Care Quality Commission (CQC) inspectors to capture the experiences of people who use services who may not be able to express this for themselves. During the inspection we saw how the staff interacted with people using the service. We also observed care and support being provided in the homes communal areas.

We spoke with twenty people who used the service, five relatives, one chef, three senior health care assistants (SHCA's) the registered manager, the general manager, five health care assistants (HCA's) one domestic, one laundry assistant, a visiting GP, two visiting health protection nurses, the receptionist, the training officer, one registered nurse and a nurse whose nurse registration had lapsed. We walked around the home and looked in all of the bedrooms on both floors. We looked in all of the communal areas, the kitchen, shared toilets and bathrooms. We reviewed a range of records about people's care which included the care plans for five people, the medicine records for five people, the training and supervision and recruitment records for four staff employed at the home, and records relating to how the home was run.

Inadequate

Is the service safe?

Our findings

People spoken with told us they felt safe and had no complaints or concerns about the care provided. Three people spoken with said, "they treat you like a human being", "I feel safe and comfortable" and "I have no complaints; they are brilliant". However a relative said, "the care is tolerable; I know all the staff and there aren't enough" and "the staff do a reasonable job. Also buzzer problems, where my mother's call bell had been removed or disconnected".

Some of the people living at Cale Green Nursing Home were unable to give their verbal opinion about the care and support they received therefore we used a short observational framework for inspection (SOFI) which is a tool used by the Care Quality Commission (CQC) inspectors to capture the experiences of people who may not be able to express this for themselves. Using the SOFI we observed staff using equipment, such as a hoist and staff carried out their care duties in a respectful manner. We saw a high number of people spent their time in bed and there were no records to show that these people were being checked on regularly by staff to make sure they were safe and their needs were being met.

The registered manager (RM) said that staffing levels were sufficient to meet the needs of the people who used the service. We looked at the staff rota which did not confirm the care staff deployment described by the manager. We noted that the home was operating with reduced health care assistants (HCA's) and staff spoken with confirmed that they were short staffed on the first day of our inspection. They said "we just have to manage". From our observations we noted that staff were hurried while carrying out their duties. When asked, the manager felt that nobody was at risk due to the staff absence, "we're just very busy" they said.

On the first day of our inspection we saw there was one registered nurse (RN) on duty. When we spoke with the RN he confirmed that he was the qualified nurse on duty responsible for 21 people receiving nursing care on both floors of the home and that his day shift was over a 12 hour period from 8am to 8pm. We checked the nurse staffing rota and it confirmed the RN deployment as described.

There was a recruitment and selection procedure in place. We looked at five staff recruitment files and found that not all of the staff had been recruited in line with the regulations and pre-employment checks had not been carried out. Pre-employment checks help to protect people from the risk of unsuitable staff being employed.

We spoke with a HCA who was working their first day at the home. We asked them if they had a work permit to work in England. They told us that they needed a work permit but the RM had not asked them to produce the permit before starting work at the home. Undertaking the relevant pre-employment checks before the person starts work at the home would help to mitigate the risks associated with employing unsuitable people.

We looked at the recruitment files that belonged to four HCA's and saw that one person had an incomplete employment history on their application form. We saw that a person who had worked at the home as a domestic recently changed their role to HCA however an enhanced Disclosure and Barring Service (DBS) check had not been carried out. We saw that a registered nurse application form was incomplete and there was insufficient employment history. There was no evidence the registered manager had explored this.

We saw that the recruitment records and contract of employment for another RN stated he was a registered general nurse (RGN). However when we spoke with the nurse he confirmed that he was a registered mental nurse (RMN). We asked the manager if she was aware that the details recorded were inaccurate, she said, "I'll change it later". We found that the manager was unaware that the nurse was actually RMN.

We asked to see the recruitment records of the general manager (GM). Both RM and GM advised us there were no recruitment records, interview notes, a contract of employment or a job description available for the GM. We spoke with the GM who told us he was a RMN however he disclosed to us during this inspection that he was not registered with the Nursing and Midwifery Council (NMC) and therefore not legally permitted to work as a registered nurse. The GM told us that he had delivered nursing care with clinical intervention, such as changing people's dressings, to 10 people over a five day period from 13 April 2015 to 17 April 2015 at the home. He confirmed that this intervention had taken place when there were no registered nurses to cover the day shifts at the home. This meant that people were at risk of receiving inappropriate and unsafe care.

Inadequate

Is the service safe?

Evidence from the staff rota and a discussion with the GM showed that the GM regularly took charge of the home and was responsible for the nursing care being delivered. The GM advised us that he and another unregistered nurse had undertaken many aspects of nursing care by using their nurse status even though they were not registered to practice as a nurse. The GM confirmed they had carried out clinical interventions such as wound care, administering subcutaneous injections, completing and forwarding referrals to other healthcare professionals and being clinically responsible for the delivery of nursing care to 28 people at the home. The GM gave us a hand written list that included the names of 10 people who had received clinical nurse interventions from him.

The RM explained that the general manager was initially employed as a consultant to the home and was put on the 'payroll' as the GM in January 2015. The RM confirmed they had not carried out new pre-employment checks as part of the home's recruitment process including a DBS check. These checks would have confirmed a lapsed nurse registration and the person's unsuitability to carry out nursing tasks at the home. There was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed.

On the second day of our inspection we looked at a completed application form for another person who began working at the home as a registered nurse (RN) in January 2015. On their application form they stated their nurse registration had expired in August 2014. However, we looked at a copy of the person's nurse registration identification card which confirmed their registration had actually expired in August 2013. This meant that the person was operating without registration as a nurse at the home and people were at risk of receiving inappropriate and unsafe care. We informed the RM of our findings and they produced a copy of 'nurse practitioner details' for the nurse. When we looked at the details we found they belonged to a different nurse with different registration details, who had the same name but was registered in another part of the country. The RM removed the nurse from the nurse staff rota immediately after we told her that the nurse was operating without a valid personal identification number (PIN) and registration.

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

We also found that a DBS check for the same person was issued to the home on 25 February 2015 but the person had started work at the home on 27 January 2015. There was no evidence that an Independent Safeguarding Authority (ISA) check had been carried out. We found that the provider had not carried out the necessary pre-employment checks to safeguard people from the risk of inappropriate and unsafe care.

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

Following these findings on the second day of our inspection, we identified from looking at the nurse rota that there were no RN's to cover the day shift at the home between 3pm and 8pm. We asked the RM what she intended to do to cover the nurse shift because people would require their evening medicines. None of the care staff had been trained to administer medicines and nursing care. The RM immediately contacted a nursing agency and told us that they knew the nurse who would arrive shortly because they had worked at the home previously. They told us the nurses' name and expected that she would arrive shortly.

At 6.30pm another nurse [not the expected named nurse] from the agency arrived at the home without any credible identification and produced a photo name card with 'RGN' written on it. The person had not brought with them their registration details or PIN. We noted that the RM did not check that the nurse ID against the NMC register until we reminded her that she had not carried out the necessary pre-employment checks.

We saw there were no registered nurses at the home when people required their evening medicines on the first day of the inspection. This included two people with diabetes who had not received their Insulin at the prescribed time and three people had not received their warfarin medication at the prescribed time. A district nurse was called to the home to administer a person's insulin injection as a matter of urgency because the person's blood sugar reading was becoming dangerously high.

Other people received their medicines later than prescribed and some people were not given their evening

medicine. Following this occurrence, the CQC alerted the local authority adult safeguarding team of our concerns because there were no registered nurses to cover the day shift at the home and the potential risks to people associated with missed and late medicines. This was in breach of regulation13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

The home had a medicine policy and procedure that was usually followed in practice. During the inspection we saw that medicines were stored safely and records were kept for medicines received and disposed of; this included controlled drugs (CD's). We looked at the medication administration records (MAR) for six people and found that medicines had been signed as being given as prescribed. We observed part of an afternoon medicine round and saw that medicines were administered by the nurse whose registration had lapsed.

When we spoke to the nurse it was later disclosed that her nurse registration had been suspended following a medicines error that occurred at a National Health Service (NHS) hospital. She confirmed she had a supervision order in relation to handling medicines. The GM confirmed that he had also administered medicines to people at the home without having completed the necessary training to do so. Therefore people were at risk of harm and subject to medicine errors and from staff who were not suitably trained and competent.

This was in breach of regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We walked around the home and found that some bedrooms were dirty and furniture was in a poor state of repair. We saw rubbish and stale food under a bed that was being used, light shades had a layer of dust and wall paper was peeling off a bedroom wall. We saw a commode seat was worn, split and dirty, a bed head was stained and not made of material that could be wiped clean and the over bed tables were dirty.

Two Local Authority health protection nurses carried out an infection control inspection on the same day as the CQC inspection visit. They showed us a number of mattresses, pressure cushions and mattress covers that were torn and some mattress internal foam was, saturated, had an offensive odour and were heavily stained. This meant that people were at risk of cross infection. The RM was advised that some of the mattresses and pressure cushions were unsafe and unfit for use. During our inspection four mattresses were replaced with new ones.

We looked at the domestic staff rota and saw that there were two people on duty from 8am to 2pm (one person on each floor of the home) also one person from 2pm to 8pm and a laundry assistant in place. One domestic was responsible for cleaning 50 bedrooms which included 12 bedrooms with an en-suite facility, all communal bathrooms/shower rooms and toilets, office areas, two large lounge/dining rooms, a quiet lounge, all corridors, the reception area and all the windows in the home. From our findings when we walked around the home it was apparent there were insufficient domestic staff to keep the home clean and safe and protect people from the risk of cross infection.

This was in breach of regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

In another bedroom we saw that a raised toilet seat was loose which meant that people were at risk of falling off. We also saw that the floor covering was stained black at the back of the toilet and there was a hole in the door which separated the en-suite from the bedroom. We looked at the maintenance log sheets and found that a number of identified repairs had not been indicated on the log sheet as completed.

On the second day of the inspection we looked around the home to check if the repairs had been carried out and we found that all of the repairs noted were still outstanding. These included dripping taps of which one had been reported on the 16 March 2015, a toilet that was not flushing was reported on 17 April 2015 and a light not working in an upstairs toilet was reported 25 April 2015 and we were told that a suitable light bulb was not available for that toilet area. The RM did not confirm how the toilet lighting would be restored to make sure the area was safe for people to use.

We found that maintenance log entries did not always give the room number but were identified by the person who was living in that room. This might make auditing maintenance tasks difficult to identify if people left the

Inadequate

Is the service safe?

home or moved rooms. A broken window pane located in a ground floor communal room which was used by the inspection team during our visit was repaired on the second day of our inspection.

Since our last inspection the CQC received a number of concerns about the service which we raised with the local authority (LA) adult safeguarding team. We contacted the LA for their views about the care provided in the home and they advised us they had received a high number of safeguarding alerts and whistleblowing concerns about the home prior to our inspection.

Procedures were in place to make sure any concerns about people's safety were reported using the home's safeguarding procedure which was in line with the local authority 'safeguarding adults at risk multi agency policy'. Staff spoken with explained how they would recognise and report abuse and they knew how to access the homes safeguarding policy which was kept in the staff office. Staff knew how to report poor practice by their colleagues through the use of the home's whistleblowing policy.

We looked at the care records for six people and saw that not all individual risks to people's safety had been properly reviewed and did not properly identify how risks would be managed. We saw records that showed the service recorded people's falls and we saw that 24 falls had occurred within the home since January 2015. We noted that one particular person had fallen on six separate occasions, but could not find any written evidence to show that the person had been referred to the falls management service or that a risk assessment had been developed to manage this. Risks of falls were not mitigated because there was a lack of detailed risk assessment about people's safety.

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

Inadequate

Is the service effective?

Our findings

We asked people if they felt they were cared for by staff who were skilled and knowledgeable. People spoken with told us they felt the staff knew what they were doing. One person spoken with made positive comments about the meals served such as, "I'm vegetarian. The chef listens to me. I have quiche and I love beetroot. They buy it in and sort it out for me".

We looked in the home's kitchen and saw people's dietary requirements, likes and dislikes had been noted and were kept in the kitchen. The kitchen was clean and food served had been cooked using fresh ingredients. The chef told us that people were asked for their meal choice each day by care staff, and that food preferences were noted and recorded. The chef showed us an up to date record of people's dietary requirements and told us that the list was regularly updated. We noted that the kitchen had recently been inspected by the environmental health department and had given a five rating for hygiene and cleanliness.

There was a choice of two main courses and two puddings. People were given a hot or cold drink of their choice with their meal. We sampled the food served on the second day of the inspection and found that it looked appetising, was flavoursome, balanced and nutritious.

We saw there was no attempt made to make a social occasion of the main meal served. Tables were not laid and no menus were on display. On the day of our inspection only four residents had lunch in the dining area of the ground floor lounge. This dining area was shared with people who lived in a supported tenancy owned by the provider. All lunches were transported by staff on trays direct from the kitchen to people's rooms. We saw a copy of the menu was available at the home's reception.

People who required a soft or pureed meal were assisted by staff to maintain their nutrition. We observed two people were supported to eat whilst lying in their bed. We saw staff standing up over the bed whilst assisting the person to eat. It was not clear if the bed had been adjusted to make the persons lunchtime experience more comfortable and relaxed. We spoke with the training officer and showed him how one particular person was assisted to eat their meal. The training officer made a note of our comments and said, "I think this might be an issue which can be addressed through training". This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

The GM told us that he was responsible for the clinical supervision of a nurse at the home. He told us he had recently mentored the nurse who had a supervision order as part of their nurse registration. We looked at records that confirmed the nurse had received a targeted supervision which was provided by the GM. However the GM's nurse registration had lapsed and therefore he was not eligible to provide clinical supervision to the nurse. This meant that the provider could not demonstrate that nurses working at the home had an acceptable level of competence to carry out their role unsupervised.

From the six HCA's spoken with, five of them confirmed they had received a satisfactory staff induction at the start of their employment at Cale Green Nursing Home that covered the necessary areas which helped to integrate a new worker into their role. One HCA was working their first day at the home and when asked about their induction told and us that they had not yet been shown the fire procedure but had assisted other HCA's with their daily routines as part of her induction.

We looked at the supervision and appraisal records of six HCA's and saw that none of them had received formal supervision between January 2015 and April 2015. Whilst we did not see any written evidence that staff received regular supervision or an annual appraisal we saw that an observational supervision had taken place whilst people were working. We saw that the training officer had observed a HCA moving a person in bed which required the use of a slide sheet. It was recorded that a slide sheet was not available and the staff was instructed to use a bed sheet; this is considered to be unsafe practice. It is good practice for each person to have two slide sheets each which can be used personally for them and prevent cross infection between people living at the home. The staff observation sheets had not been updated to include safe practices. There were breaches of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

We also noted that written information contained in another observational supervision record stated that a care worker dipped their elbow in the bath water to check the water temperature because there was no thermometer.

Inadequate

Is the service effective?

This practice is unsafe and cannot be relied on because people have different sensitivity to heat. The care worker had also asked the person who was having a bath to check the water themselves to make sure it was a suitable temperature for them.

This was in breach of regulation 12(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Staff spoken with told us that there were no thermometers available to check the water temperature. On the second day of our inspection visit we found thermometers were in place and a notice was displayed in the bathroom informing staff that they had to record the temperature of the water on a chart. However there was no water temperature chart in place.

When we walked around the home we looked in some of the bedrooms. We saw that some bedside cabinets were chipped at the corners. We also found cigarette burns on a bedroom floor. One bed had a wheel missing and had been propped up with a piece of folded vinyl. A bed wheel was also missing from the leg of another bed and was resting on a piece of wood to protect the carpet. Staff told us that it was difficult to move the bed to clean underneath and down the side of it because the bed was up against the wall. We saw a wardrobe was being propped up with folded cardboard from the inside of two toilet rolls. We saw stained bed frames and we saw sheets that were threadbare and stained. We were told that although this was dated on the maintenance log on the 20 April 2015 for repair, these repairs were longstanding and had not been followed up as a priority. This was in breach of regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment

We looked at the staff training and development plan which showed most of the staff had received core and refresher training in subjects such as fire safety, moving and handling, infection control and safeguarding. This helped to make sure staff knowledge, skills and understanding was up to date. Staff had undertaken training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). They were aware of their duties when these restrictions were in place. These safeguards protect the interests of vulnerable people and help to make sure people are given the care they need in the least restrictive way.

We saw that some people had undergone an initial capacity assessment carried out by the home. However we were unable to find further evidence that DoLS applications had been made and that people were being protected by DoLS.

Following the inspection we spoke with a member of the local authority safeguarding adult mental capacity act service (SAMCAS) team. We asked them to advise us of the number of DoLS applications made to them by the home. They told us that although they had received a list of people's names in July 2014, who might require a DoLS the registered manager had not progressed the named people to the assessment stage. This meant that the home might be depriving people of their liberty illegally.

This was in breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

Requires Improvement

Is the service caring?

Our findings

People spoken with told us they were happy with the care and support provided at the home. When asked if they felt cared for people said, “I am very happy here”, “I would not complain, the staff are nice”.

When we walked around the building we saw that the nurse call bell in three bedrooms had been rolled up and tucked under the bed which prevented people from using them in an emergency. Some hand controls used to elevate the beds had also been tucked under the bed and were not accessible to people. We asked a senior health care assistant (SHCA) to check if they were working and we found that neither of them were. We also saw that a call bell was situated on the opposite side of the room from the bed and was disconnected. This meant that people’s dignity and independence was not promoted or protected.

There were breaches of regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Staff spoken with told us they had been trained in how to respect people’s privacy and dignity, and understood how to put this into practice when providing care to people. Throughout the inspection and from our observations using a short observational framework inspection (SOFI) we saw staff caringly respecting people’s privacy and dignity when they were supporting people around the home. We saw staff showing warmth and friendship to people and they spoke to them in a kind, comforting and sensitive manner. This helped to make sure people’s wellbeing was promoted.

The provider used an in house programme for people nearing end of life. The aim of the programme is to ensure people receive high quality end of life care provided by the care home and encompasses the philosophy of palliative care. We looked at the staff learning and development plan and saw that all staff had received up to date palliative care training.

The general manager explained the processes and resources available to people when they might require such care. They said, “families always had the opportunity to be close to their relative during this time and special arrangements would be put in place for families to stay close to their relative after they had died”. They told us during this time regular assessments and reviews would be carried out by appropriate professionals such as a general practitioner (GP) and district nurse who would help to make sure people could reach the end of life in the place and the manner of their choosing.

Inadequate

Is the service responsive?

Our findings

When asked about their lives at Cale Green Nursing Home people said, "there's not much to do here", "We have music and sing-songs sometimes", "we have bingo but I don't know of any outings" and "we play bingo". People spoken with told us they knew how to make a complaint and felt their complaints would be taken seriously.

However one person felt that the care and treatment provided by the home was not responsive to their needs and said, "I am hungry all the time", "they [staff] don't get me out of bed". We saw that the person was very thin and still in bed at 2pm in the afternoon and their bedroom curtains were still drawn. When we spoke to the person's relative they told us that their mother had been placed on a pureed diet on arrival at the home and despite their constant complaints to the manager this had only just been rectified. They felt that this was the reason why their mother was now so thin, "because she found the pureed food vile".

Another relative said, "I had had problems in the past with my mother's care here, and my mother had regular water infections which the staff had not noticed".

We looked at the care records that belonged to five people. All of the care files we looked at were not person centred and did not identify people's individual needs and associated risks. For example from the care files we looked at we saw that a management plan to support people with poor dietary and fluid intake was not in place.

We saw that a person was at risk of malnutrition and nursing care records showed that person was offered only 425mls of fluid over a 24 hour period. According to another nursing care plan, one person had lost 2.6kg of weight over a seven day period but a referral had not been made for the person to be seen by the GP.

We looked at a weight record for another person who had had lost nearly 12kg over a period of seven months and found there were no management plans in place to monitor the person's weight. We also saw that there was no risk assessments in place to mitigate the risk of malnutrition for the people whose care files we looked at.

The general manager provided us with an untitled document which included the name of each resident and a weight in kilograms next to the person's name. In another column on the document comments about each person had been written in a way that was not person centred and was impersonal, such as, "please observe weight, please re-weigh if correct please speak with GP about drop in weight, observe and MUST & BMI 1 please refer to dietician". We looked in people's care plans to check if the comments had been followed up but we were unable to find information in the care plans that showed the comments had been progressed or actioned.

We saw that staff had not followed the guidance about using a 'Waterlow' pressure ulcer risk assessment tool. People who had been assessed and had a reported risk score of 20 required weekly Waterlow risk assessment reviews. Most of the people assessed against the Waterlow tool showed a score of 25 and above but the documentation that we looked at showed that risk assessments were being completed monthly rather than weekly.

The GM also advised us that he and two other unregistered nurses and the registered manager had written care plans for nursing resident's, carried out nursing assessments alongside planning, reviewing and evaluating the nursing care of 28 people at the home. This meant that people were not protected from the risks of receiving inappropriate, unsafe care and treatment from unregistered nurses and non nursing staff.

This was a breach of regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We asked a nurse at the home to tell us how many people living at the home had developed skin pressure damage in the form of moisture lesions and pressure sores. The nurse advised us that two people had developed skin damage, but told us she was unfamiliar with pressure sores and moisture lesions and the management of such wounds. One person was reported to have a grade four pressure sore which had been referred to the community tissue viability nurse (TVN). The second person was reported to have a grade two pressure sore on their sacral area.

The nurse gained the consent of the second person which enabled us to inspect their pressure area. We saw that the wound on the sacral area was covered with a dressing. This was removed and the reported area was found to have the definite characteristics of a moisture lesion and not a grade 2 pressure sore. As a result of this examination we found

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Is the service responsive?

the person had been receiving incorrect wound care because the wound dressing had been carried out by unregistered nurses. Best practice for managing moisture lesions is to leave the area exposed and apply a prescribed barrier cream to the surrounding skin. The registered manager did not comment when we informed her of our finding.

There were breaches of regulation 12 (1) and 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

There was an activity coordinator employed to help people engage in appropriate activities to meet their needs. The general manager provided us with an A4 piece of paper and told us that it was a copy of the activities planner. We saw that the planner included two activities each day such as, 'coffee morning and board games, resident's tuck shop and books and reminiscence (old times) and armchair exercise. When asked, people told us they had not been involved in choosing activities for the planner. This meant that people's preferences about the way they spent their time was not considered in a person centred way. Throughout our inspection we saw people sitting in communal areas sleeping or uninvolved in any form of meaningful activity.

There was a breach of regulation 9(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

We spoke with the activities coordinator who was in the lounge talking to three residents and playing a game of cards with one of them. She told us that plenty of activities go on during the course of the week, which she supervised. She mentioned reminiscence sessions, sing-alongs, comedy sessions, walkabouts, arm chair exercises, bubble-blowing and raffles. As so few people seemed to sit in the lounge area, it was unclear how many residents this actually involved and a record of activity participants was not kept. She told us it was difficult to get some residents out of their rooms for activities, but that she tried to involve them all. The activity coordinator did not suggest that activities were offered to people on an individual basis who were unable to come out of their room.

We saw there was a complaints procedure in place which was available to people who used the service and their relatives. We saw that any complaints made to the home since our last inspection had been addressed and responded to within the service's complaints procedure timescale.

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Is the service well-led?

Our findings

A registered manager was in place at the home. The registered manager shares her time in this position over two nursing homes.

On the first day of our inspection the Cale Green Nursing Home management team was made up of a registered manager and a general manager. The registered manager was responsible for the overall running of the service. We could not determine the role of the general manager because there was no job description for this position.

Our inspection process puts people who use services at the heart of what we do. We asked people who used the service and their relatives for their opinions about how the home was run. One relative was highly critical of the home, and said, "disgraceful place, the manager [registered manager] is rude and arrogant; it's taken some time but my mother's food has improved since I complained". We watched the relative get his mother out of bed and into a wheelchair then took her outside and said, "surely this is something that the staff should have done". Another relative said, "the staff are very pleasant and the manageress seems ok".

When we arrived at the home on the first day of our inspection we gave the manager a list of documents we required for the purpose of our inspection. We asked the registered manager for the records kept to assess and monitor the quality of the service and health care provided at the home.

We found there was a system in place for gathering feedback about the quality of the service provided from people who lived at the home. However when we asked for the results of the most recent service user satisfaction survey, the manager gave us seven completed external professional feedback questionnaires. The forms had been completed between April 2014 and April 2015. Three of the questionnaires had been completed by district nurses and another was completed by a clinical commissioning group (CCG) assessor. Three other forms were anonymous. Overall the forms indicated that seven people agreed the home provided a good service to people who lived there.

The manager could not provide any evidence that people who used the service, their relatives or staff had been asked to complete a satisfaction questionnaire. This meant that the manager could not act on feedback from people to evaluate and improve services because people were not consulted in order to gain their views and opinions about the quality of the service provided at the home. There is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

When we looked at the records that had been given to us we found some of the records that were meant to be completed on a monthly basis such as audits in relation to health and safety, risk assessments, care plans, accidents and incidents, complaints and concerns, were last completed in September 2014 and had not been kept up to date.

We saw that these out of date records were unclear because the manager had written comments that could not be used to identify where quality and safety was being compromised.

The registered manager told us that the general manager was responsible for monitoring and auditing the quality and safety of the service. However the general manager disagreed and told us that he understood it was the registered manager's role to do this. He stated that he was not employed to manage the home and was unable to be the home's clinical nurse lead because he had no valid and up to date nurse registration.

The registered manager then suggested that a senior health care assistant (SHCA) could adopt the role of clinical nurse lead. We advised the registered manager that this would not be possible because the role had to be undertaken by a registered nurse and the SHCA was not a registered nurse.

We found that there was a lack of consistent leadership and communication systems between the staff at the home were not effective. It was apparent that the RM and GM were unclear about their roles and the systems in the home. It was also apparent that the registered manager did not have a clear understanding about the clinical responsibilities of a registered nurse. This lack of understanding could put people at risk of harm from receiving unsafe and inappropriate care.

From the discussion held between the registered manager and general manager it was apparent that people were not protected because the provider did not have effective systems in place to monitor and assess the quality of the service provided or mitigate risks relating to the health,

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safety and welfare of people using the service. We found that people living at Cale Green Nursing Home were at significant risk of receiving unsafe and inappropriate care because appropriate governance systems and process were not in place. There were breaches of regulation 17(1)&(2)(a)(b)(c) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

The registered manager failed to inform the inspection team immediately when she first became aware of the GM unregistered nurse status. She told us that she was going to advise us on the last day of our inspection. There was a breach of regulation 20(2)(a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Duty of candour.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care This was in breach of Regulation 9(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care How the regulation was not being met: We found that the provider did not ensure people's preferences were considered in a person centred way because people had not been involved in choosing the activities at the home or consulted to gain their views and opinions about the quality of the service provided at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was in breach of Regulation 12(1) (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. How the regulation was not being met: We found that the provider did not protect people against the risks of unsafe and inappropriate care because pre-employment checks were not carried out to prevent unregistered nurses from working at the home.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was in breach of Regulation 12(1) (2)(a)(b(e)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment How the regulation was not being met. We found that people who used the service were not protected against the risk of the spread of infection because equipment used by service users was not safe and risks were not mitigated or controlled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment This was a breach of Regulation 15(1)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment. How the regulation was not being met: We found that the provider did not protect people against the risk of cross infection and injury because the premises, furniture and equipment was not cleaned regularly or properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing This was a breach of Regulation 18(1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

We found that people who used the service were not protected against the risk of receiving unsafe and inappropriate care because staff had not received regular supervision and appraisals to help them carry out their duties safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines This was a breach of Regulation13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment. How the regulation was not being met. We found that people who used the service were not protected against the risks associated with missed and late medicines because no trained and competent staff were available to administer medicines to service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing This was a breach of Regulation 18(1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing How the regulation was not being met. We found that people who used the service were not protected against the risk of receiving unsafe and inappropriate care because the provider had not deployed sufficient numbers of suitably qualified and competent staff at the home.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour This was a breach of Regulation 20(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Duty of Candour. How the regulation was not being met. We found that the provider did not act in an open and transparent way by notifying the Care Quality Commission about the unregistered nurses employed at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment This was in breach of Regulation (15)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment How the regulation was not being met: We found that the provider did not promote people's dignity and independence because some call bells and bed controls had been placed underneath beds or disconnected and were not accessible for people to use.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment This was in breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met.

We found that people who used the service were not protected against the risks associated with being deprived of their liberty because the provider had not submitted the appropriate DoLS assessment forms to the local authority.