Chestnut Care Limited

Savile House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 November 2016 and was unannounced. At the last inspection on 22 October 2015 we rated the service as 'Requires Improvement' and found the service was meeting the regulations.

Savile House provides personal care for up to 24 older people, some of who may be living with dementia. There were 17 people using the service when we visited. Accommodation is provided on three floors, there are single and shared rooms and some have en-suite facilities. There are communal areas on the ground floor, including a lounge, dining room and conservatory.

The home has a registered manager. 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.

Prior to this inspection we had received concerns about the management of the home, staffing levels, moving and handling practices and the suitability of the premises when people required the use of a hoist. We identified the same concerns during the inspection.

Due to personal circumstances the registered manager had taken several periods of leave over recent months which had left the deputy manager in charge of the home and this situation was ongoing. We were concerned the deputy manager was inexperienced and was not provided with the resources and support required to take on this role. The deputy manager had two days a week in the office and the rest of the time was included in the staffing numbers as part of the care team delivering care to people while at the same time managing the service. We informed the provider of our concerns during the inspection and made referrals to the Local Authority safeguarding team where we identified people were at risk.

There were not enough staff deployed to meet people's needs. Staff rotas showed the levels of care staff frequently fell below the levels the registered manager told us were in place. Staff who did the cleaning and worked in the laundry and kitchen were employed part time and when they were not present these tasks were completed by the care staff. We saw care staff making the tea time meal and breaking off to assist people to the toilet before returning to the kitchen. Although they washed their hands and changed protective clothing this was not acceptable.

Risks were not well managed. There were no arrangements in place to ensure that people who required a hoist to transfer were provided with suitable accommodation to allow this to be done safely. For example, none of the communal toilets on the ground floor could accommodate a wheelchair and hoist safely or in a way that maintained people's privacy and dignity. Moving and handling assessments and care plans provided conflicting advice about the equipment and aids to be used. Medicines were not managed safely or effectively which meant we could not be assured people were receiving their medicines as prescribed or

when they needed them.

Recruitment procedures were not always robust. For example, there was no evidence to show appropriate action had been taken in response to concerning information received through recruitment checks for one applicant.

Staff received induction and training however, we found this was not always thorough. For example, we identified one staff member did not have the skills or competency to carry out their role. We raised this with the provider who took immediate action to address the matter and stated they would provide them with additional training. However, we were concerned this had not been identified by the registered manager or provider through their own processes.

People told us they enjoyed the food and we saw staff supported people with their meals. However, we found the systems in place to monitor people's weight and to make sure they had enough to eat and drink were not effective. We saw one person had lost a significant amount of weight yet it was not clear what action was being taken to address this.

We saw people enjoyed a quiz that took place in one of the lounges and the staff member was enthusiastic and encouraged people to participate. People told us they had enjoyed a recent trip to Blackpool when they had eaten fish and chips and seen the illuminations. They said other trips out were planned in the run up to Christmas. People told us the staff were kind and caring and were happy with the care they received. People looked comfortable and well dressed and staff treated them with respect. However, there were shortfalls in the building which compromised people's dignity and privacy such as no working locks on toilet doors, although the deputy manager told us these were repaired the day after our inspection.

People's care records were not person-centred and did not reflect people's needs or preferences. There was a complaints procedure displayed. The registered manager told us they had received no complaints.

A new quality assurance system had been recently put in place by the provider. However, although there were plenty of audits completed these were not effective as issues we identified during this inspection had not been picked up or addressed through these processes.

We found there was a lack of effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. We found shortfalls in the care and service provided to people. We identified eight breaches in regulations – regulation 18 (staffing), regulation 14 (nutrition), regulation 12 (safe care and treatment), regulation 10 (dignity and respect), regulation 9 (person-centred care), regulation 15 (premises), regulation 19 (fit and proper persons) and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines management was not safe and effective, which meant we could not be assured people received their medicines as prescribed.

Staffing levels were insufficient to meet people's needs in a timely manner. Staff recruitment processes were not robust as checks were not completed before new staff started work to ensure their suitability to work in the care service.

Risks to people's health, safety and welfare were not assessed and mitigated. Safeguarding incidents were recognised, dealt with and reported appropriately.

Effective systems were not in place to ensure the premises were suitable for the people who used the service and well maintained.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received the induction, training and support they required to fulfil their roles and meet people's needs

The service was not meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not met.

People's healthcare needs were assessed and staff supported people in accessing a range of health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives told us staff were kind and caring and this was confirmed through our observations.

People's privacy and dignity was not always respected and maintained by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not person-centred and did not reflect people's preferences.

Activities were provided and trips out were being arranged. We saw people enjoying activities on the day of the inspection.

Systems were in place to record, investigate and respond to complaints, although no complaints had been received.

Is the service well-led?

Inadequate

The service was not well-led.

Effective quality assurance systems were not in place to assess, monitor and improve the quality of the service and we identified several regulatory breaches.

The registered manager's intermittent absences had had a detrimental effect on the leadership and management of the home, although the deputy manager was committed and willing to improve the service they were not provided with the resources or support required to enable them to do so.

Savile House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 16 November 2016 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report.

We observed how care and support was provided to people. We spoke with five people who were living at the home, three visitors, a senior care worker, two care workers, the deputy manager, the registered manager and the registered provider.

We looked at four people's care records, two staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

We found systems and processes in place to manage medicines were not safe or effective. Medicine administration records (MARs) were poorly completed and it was not always clear if people had received their medicines as prescribed. We saw two people were prescribed an anti-coagulant (a medicine which thins the blood). The dosage of these medicines varies according to the results of regular blood tests. We were concerned both of these people were not receiving these medicines as prescribed. For example, one person was prescribed a 5mg dose to be given daily Monday to Friday and at the weekend the daily dose was reduced to 4mgs. The MAR showed this person had been given the incorrect dose on both days at the weekend prior to the inspection. We checked the stock levels of these medicines with a senior staff member but were not able to reconcile the number of tablets with the amounts recorded. This meant we could not establish if these medicines had been administered as prescribed. We also found some of the medicines being used had expired in September 2016. We reported our concerns to the registered provider and asked them to contact the person's GP.

We saw another person was prescribed a medicine to treat osteoporosis which was to be administered on the same day each week. The MAR showed over a three week period this medicine had only been administered correctly once as it had not been signed as given in the first week and had been given on the wrong day in the second week. There were no stock levels recorded for this medicine therefore we could not establish if the medicine had been administered as prescribed. We saw this person was also prescribed a nutritional supplement to be given daily. The MAR showed this had not been administered for seven days as it had been refused, yet the person had been taking it regularly prior to this. There was no record to show why it was refused or that this had been brought to the attention of any healthcare professionals.

We were not able to establish if topical medicines, creams and lotions were being administered as prescribed due to the lack of information about how, where and when these medicines should be applied. For example, we saw one person was prescribed an anti-fungal cream and the MAR stated apply '2 – 3 times daily'. There was no information on or with the MAR to show where this cream should be applied. We asked the senior staff member who said they thought it went on the person's body but was not sure where as they said the person had two creams which staff applied.

We saw a lack of robust protocols where people were prescribed medicines to be taken 'as required'. For example, where people were prescribed pain killers to be given 'as required' there were no clear protocols or information to guide staff about how to identify when people were in pain. Staff were also not always recording the time and number of tablets given when people had taken their 'as required' medicine.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs (CD). The senior staff member told us one person was prescribed a CD. We checked the MAR and CD register which showed the medicine had been administered as prescribed.

We found most medicines were stored safely and securely, however staff told us two people were prescribed a thickening agent and we saw these were kept in the kitchen which was accessible to people who used the

service. Instructions on the packaging showed the thickening agent should be kept at a temperature below 25°C. Although there was not a thermometer in the kitchen it was clear the temperature was higher than this. The thickening agent for one of these people was not prescribed on the MAR. Thickening agents are prescribed medicines for individual use only and need to be kept securely.

We looked at the provider's medicines policy which was dated 23 February 2005 although it stated the policy had been reviewed in January 2015. The policy did not reflect current guidance as found in the National Institute for Health and Care Excellence (NICE) document "Managing medicines in care homes guideline (March 2014). For example, there was no information about covert medicines. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection we made a safeguarding referral to the local authority safeguarding team about the medicine concerns we had found.

At our last inspection we had stated that the staffing levels needed to be reviewed as we considered they were at minimal levels although at that time we found this had not impacted on the care people received. Prior to this inspection we received concerns about the staffing levels in the home and the long hours staff were working. The registered manager told us the usual staffing levels were three care staff from 8am until 10pm and two care staff from 10pm until 8am. A laundry staff member was employed for ten hours a week and a domestic staff member worked 15 hours per week. The cook was employed from 8am until 12 midday, Monday to Friday. The registered manager confirmed there was no weekend cook. They told us three care staff were currently absent as was the laundry person. They told us the laundry person was going to start doing activities but this had not happened due to their absence. This meant the care staff were frequently responsible for laundry, cleaning, cooking and activities as well as providing care to people.

We found there were not enough staff deployed to meet people's needs. This was confirmed in our discussions with staff. They told us there were three people who required two staff to assist them and one of those people sometimes required three staff. There was no laundry person or cleaner working on the day of inspection, which meant these tasks had to be completed by the care staff. We saw when the cook had left for the day the care staff struggled to carry out catering tasks, while at the same time providing care and support to people. We saw the senior staff member administering the medicines while the two care staff were preparing, cooking and serving the evening meal. We saw the care staff member making the meal was continually called away to assist their colleague in delivering personal care. Although we saw the staff member washed their hands and put on an apron when they re-entered the kitchen the potential risk of cross-contamination was high. Duty rotas we reviewed for the four weeks leading up to and including the inspection showed the staffing levels stated by the registered manager were not being maintained. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found robust recruitment procedures had not been followed to ensure staff were suitable to work in the care service. We saw a reference in one staff member's file which showed they had been dismissed from their previous employment for gross misconduct. The registered manager had made a note on this reference saying they had discussed this on the phone but did not say who with or the outcome of the discussion. This staff member also had a criminal record check from the Disclosure and Barring Service (DBS) which showed they had previous convictions. There was no evidence to show the registered manager had discussed either the convictions or the dismissal with the staff member or carried out a risk assessment to determine their suitability to be employed in the care service. This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the accident book and saw over a three month period one person had had six falls and another person had had nine falls. The deputy manager said the GP had been informed about the person

who had sustained nine falls and said the GP did not think a referral to the falls team was needed. We asked the deputy manager if falls risk assessments had been completed for these two people and if they had care plans in place to advise staff on the actions they should take to mitigate the risk of further falls. The deputy manager said these had not been done. The deputy manager said a falls risk analysis should be completed after a person had suffered two falls. This meant people were not protected against further falls as action had not been taken to assess and mitigate the risks. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw certificates in place relating to environmental safety such as the gas safety certificate and the legionella certificate. However, we found other areas where a lack of environmental safety could put people at risk. For example, many of the bedroom doors, which were fire doors, were not closing fully into the door frame which meant in the event of a fire they would not provide effective protection to people. The deputy manager told us they had taken over all the fire safety checks from the handy person; however they said they had not received any training or instruction in how to carry out the checks or what they should be looking for and had not been checking the fire doors. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection we had received concerns about the suitability of the premises. This was in relation to the accessibility of toilets, bedrooms and bathrooms for people who required a hoist to transfer safely. We found the premises was not always suitable to meet these people's needs. The registered manager told us there were two people who required a hoist to transfer. We saw during the day most people were gathered in the communal areas on the ground floor where there were three toilets people could use. None of these toilets were accessible for people who required hoisting as they were not large enough to accommodate a hoist and wheelchair. We saw the largest of these toilets was used by staff to toilet a person who used a wheelchair and hoist. The space restrictions meant staff were unable to close the toilet door so screening curtains affixed in the area outside the toilet were used so the person could not be seen. However, this also blocked the access route to the other two toilets and we saw people asking to use the toilet were told they would have to wait. There were three other communal toilets in the home, one on the top floor and two on the first floor. Only one of these provided sufficient space to be used by people who required hoisting. Although most of the bedrooms had ensuite facilities, the two people who needed a hoist to transfer had no ensuite facilities and their bedrooms were small which we considered would make it difficult for staff to transfer and manoeuvre people safely. This was a breach of the Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they had received safeguarding training and knew the reporting systems to follow if any concerns were raised. We had been notified of safeguarding referrals that had been made to the Local Authority safeguarding team and saw appropriate action had been taken.

Inadequate

Is the service effective?

Our findings

The provider information return (PIR) completed by the provider prior to the inspection stated all staff were fully trained and received induction, supervision and appraisals. We looked at the staff files for two recently recruited staff and each had an induction checklist that covered over seventy areas of induction to the home and the job role. We saw the entire induction had been signed as delivered and completed on the same day. We spoke with the deputy manager who told us the induction lasted for six weeks. However, neither the deputy manager nor registered manager provided us with any other evidence of induction for staff.

We asked the registered manager for the training matrix. This was provided the day after the inspection. We were unable to determine from the matrix if all staff had received the training and updates they required for their job role as the dates training had been completed were not always stated.

We found evidence which showed staff were not adequately inducted or trained for their job role. For example, one senior staff member told us they had not received any formal medicines training since starting at the home. Although they had received medicines training with a previous employer they said this was a 'couple of years ago'. We observed this staff member and raised concerns with the provider about their knowledge and competency in relation to medicines and people's health care needs. Although the provider took action to address this matter when we brought this to their attention, we were concerned the staff member's competency and skills had not been determined or assured through the provider's recruitment, induction and training programmes. This placed people at risk of unsafe and inappropriate care from untrained staff.

The deputy manager was the moving and handling trainer, yet evidence elsewhere in this report shows safe moving and handling practices were not being undertaken by staff which placed people and staff at risk of injury. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us supervisions were up-to-date and staff confirmed they had received supervision. However, we did not see evidence of this in the staff files we reviewed. Following the inspection the deputy manager confirmed supervision records were available but said they had not been filed in the individual staff records.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us one person was subject to a DoLS authorisation which had been received the day before our inspection. There were no conditions applied to the DoLS.

We found the registered manager and staff lacked understanding about the MCA and DoLS. For example, the registered manager told us none of the people using the service received their medicines covertly (hidden in food or drink). However, one person living with dementia had a handwritten MAR which stated staff should administer an antibiotic by opening the capsule and putting the contents in the person's drink. When we asked the senior staff member if this was how they had administered the medicine they confirmed it was. Whilst the handwritten MAR stated the hospital had stated this medicine was to be administered covertly there was no written evidence in the person's care file to support this. We saw an entry in this person's care plan review dated 31 October 2016 which stated the GP had given permission for medicines to be crushed, yet we saw no other evidence to demonstrate the MCA 2005 was being complied with as there was no evidence of a best interest meeting or pharmacist advice.

In the care files we reviewed we saw a document where people's relatives had been asked how and when they wished to be informed of events concerning their relative. For example, in the event of falls and hospital visits. This form did not include whether the person concerned had capacity to make their own decisions about what they wanted their relatives to be informed of or whether the relative had power of attorney for care and welfare. We concluded these issues related to a lack of training and therefore found a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found people's nutritional and hydration needs were not always being met. When asked if there were any people who were losing weight or had low body weight, the registered manager said one person had lost weight but had regained this and they were no longer concerned about them. We looked at this person's care records which showed they should be weighed weekly and had lost over three stones in weight over the previous eight months. When we discussed this with the deputy manager they showed us other weight records for this person which did not reflect the weights recorded in the care file. For example, in October 2016 there were three different weights recorded ranging from 9st 6lbs to 10st 8lbs. We saw weight losses had not been calculated correctly as a weight loss of 22lbs had been recorded as 11lbs. There were also gaps of more than two weeks between the person being weighed. There was no risk assessment in place and the care plan did not include details of their weight loss or show any measures in place to mitigate the risk of further weight loss.

We found food charts for this person were incomplete and some days reflected very little intake. For example, one day's intake was recorded as a bowl of porridge, a bowl of soup, jelly and a bun and another day was one Weetabix, soup and cheesecake. No snacks were recorded and suppers were not consistently recorded as provided. For example, in one week only four supper drinks were recorded with no food offered. We found the same shortfalls in other food charts we reviewed. There was no evidence of analysis of the food charts to ensure people were receiving sufficient food and drink and the deputy manager confirmed this did not take place. This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food. We observed the lunch and tea time meals. At lunchtime we saw meals were served to people already plated with gravy on. Although people had made their choice of their main meal during the morning, serving meals already plated restricts people's choice and independence. We discussed with the deputy manager ways in which people could be supported to make choices about what they had on their plate such as placing gravy and vegetables in serving dishes so people could themselves either independently or with staff assistance. The deputy manager was enthusiastic about this

and said they would look into it. We saw staff supported people with their meals in a sensitive and respectful manner.

At tea time we observed a person to be coughing profusely whilst waiting for their meal. They were then served a bowl of very thin soup which caused their coughing to increase. This person's care records showed they required thickened fluids due to swallowing difficulties. We brought this person to the attention of a senior staff member who then attempted to give the person a drink of water. We had to intervene and ask for the water to be thickened for the person's safety. This put the person's health at risk as they were given food and drink which had not been prepared in a way which met their needs. We reported this to the provider and made a safeguarding referral to the Local Authority safeguarding team. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care records showed people had input from different healthcare professionals such as GPs, district nurses, chiropodists, dentists and opticians. We spoke with two visiting health care professionals who said people were referred to them appropriately and promptly by staff. They said any advice they gave was acted upon and felt communication was good.

Requires Improvement

Is the service caring?

Our findings

People and relatives were spoke with expressed satisfaction with the care provided. One person said, "I like it here. The staff are nice and I like the food." Another person told us, "I've settled in all right and the staff are very good." A further person said the staff were 'lovely'.

Relatives told us they visited frequently and were happy with everything. One relative said,"{Family member] has settled in well. Took a bit of getting used to but they're fine and I've no concerns." Another relative said, "We're happy with things here. No worries."

People we spoke with told us they were happy with the care they received. We saw people who were mobile and independent were able to move freely around the home and spent time chatting with other people and visitors. People told us staff were kind and treated them with respect. We observed staff were caring in their interactions with people and when time allowed chatted with people and listened, answered questions and showed interest in what they were saying. We saw one staff member had their lunch with one person and chatted to them throughout and it was clear the person enjoyed it.

People who chose to stay in their rooms told us staff always knocked on their doors before entering and we saw this ourselves. People looked clean and were comfortably dressed. We saw some rooms were personalised as people had brought in their own personal belongings such as photographs, ornaments and items of furniture.

However, we found people's privacy and dignity was not always respected. For example, none of the locks on the toilets downstairs worked which meant people's privacy and dignity was not maintained as they could not secure the door when using these facilities. One of the toilet doors was warped which meant it would not close properly, yet staff were still taking people to use this toilet. Two people's rooms had an odour of urine. The majority of the en-suites had no toilet roll holders. One person we spoke with told us they used to have one in their en-suite which was stuck onto the wall but said it kept falling off and they now balanced the toilet roll on the pipes. In another person's bedroom the drawers had collapsed in their chest of drawers and in two people's bedrooms the veneer surface had peeled off their tables. This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the deputy manager informed us the toilet door and locks had been repaired.

Requires Improvement

Is the service responsive?

Our findings

The PIR stated people's needs were assessed before they were admitted to the home and the information was used to develop a person-centred care plan. We saw pre-admission assessments completed for two people which provided information about their care needs and the support they required. However, when we looked in these people's care plans this information was not reflected. For example, one person's pre-admission assessment stated they were on a low fat and high protein diet as they had a low body mass index (BMI), were prescribed nutritional supplements and were to be weighed weekly. This information was not included in their care plan and there was no weight recorded in their care file. We looked at this person's MAR and found they had not received their nutritional supplement for the six days leading up to the inspection as they had refused it, although they had been taking it regularly up to this time. There was no reason recorded for the refusal and nothing in the care records to show staff had informed or sought advice from any healthcare professionals.

Care records we reviewed were not person-centred and did not always reflect people's current needs. For example, one person's care plan review in October 2016 showed they had eczema on their legs, used a wheelchair as they could no longer walk with a frame and only had bed baths. The care plan had been updated following the review but made no reference to any of these changes. There was no detail to inform staff what support the person required or preferred. For example, in relation to oral hygiene the care plan stated, 'Will need assistance with oral care but staff to encourage her'. There was no information to show whether the person had their own teeth or dentures or the oral care required. Similarly in relation to going to bed the care plan stated, 'Will need assistance from staff', yet it was not clear what assistance was needed, how this should be provided or how many staff were required. Another person's care records showed their health care needs included arthritis, cellulitis and diverticular disease yet these conditions were not reflected in the care plan. This meant staff may not be aware of how they could support the person to minimise any pain or other negative effects of their conditions. This person had been seen by an optician in August 2015 and had been given glasses to wear due to their poor vision. There was no reference to this in the care plan and we saw the person was not wearing glasses. The optician had recommended a further eyesight test in August 2016, yet there was no evidence to show this had taken place.

The registered manager told us there were two people who needed to use the hoist for transfers. They told us both of these people was assessed each time they needed to transfer as sometimes they were able to stand and other times needed the hoist. We found both people's care plans and risk assessments provided conflicting information about their moving and handling requirements. For example, one person's moving and handling care plan stated they needed the hoist for transfers from chair to wheelchair. There were no details about which sling to use. The moving and handling risk assessment stated no mobility aids were used. This meant the information relating to this person's moving and handling needs was inconsistent and insufficient to maintain the person's safety. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw care files included a number of assessment tools including a pressure risk assessment We found one person had been assessed as 'semi-comatose' on the pressure risk assessment tool, yet we saw this person

sat in the lounge alert and aware. We saw moving and handling risk assessments scored the risk as low, medium or high with actions to be taken according to the level of risk. For low risk the action was to explain to the person the importance of asking for help and to ensure a call bell was to hand, medium risk the advice was to ensure the person was seated before leaving them. We did not see any call bells within reach of people who were seated in the conservatory or lounge area. For people assessed as high risk the action was the same as low and medium but also stated to 'ask cognitive residents to call when high risk residents are mobilising.' We considered this advice to be wholly inappropriate. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had arranged for the laundry person to take on the role of activities organiser for two hours every afternoon. However, this staff member was currently absent from work and care staff had taken on this responsibility. During the morning of the inspection we saw people in the lounge enjoyed a quiz with one of the care staff. There were a range of general knowledge questions which generated discussions between people and some laughter. The staff member doing the quiz was engaging and encouraged people to join in.

Activity records in people's care files showed they had joined in with quizzes, sing-a-longs and skittles. One person told us there been a recent trip to Blackpool to see the illuminations and said they all had a fish chip supper which they had enjoyed. A relative told us further trips were planned in the run up to Christmas.

A complaints procedure was displayed in the home. The deputy manager told us they had not received any complaints. We saw the outcome of a recent safeguarding investigation which the deputy manager said they were going to record as a complaint within the complaints file.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who had been in post for many years. Over the last five months the leadership and management of the home had been disrupted. The registered manager had had periods of absence which were ongoing and meant the deputy manager had been managing the service. Prior to the inspection we had received concerns about the impact these changes had on the management of the home, the staffing levels and the care people received. Our inspection identified similar concerns.

The registered manager was present during the inspection but delegated much of the responsibility for the inspection to the deputy manager who we found to be approachable, open and honest. However, we were concerned the deputy manager had limited management experience and although they had two days a week in the office on other days they were included in the staff numbers therefore expected to manage the service whilst delivering care at the same time. We raised these concerns with the provider at the feedback session at the end of the inspection.

The registered manager told us the quality monitoring systems had recently been changed at the direction of the provider and the deputy manager had implemented the new system. We saw audit tools in place for a number of areas including health and safety, infection control, medications, care plans, complaints, activities, accidents and incidents and food and nutrition. We saw these audits had been completed on a monthly basis but found they were not robust and had failed to identify and resolve the majority of the issues we found during our inspection.

For example, the registered manager had completed a medicine audit the day before our inspection. Although this identified some gaps where staff had not signed the medicine administration records, none of the serious issues we found during the inspection had been identified in this audit.

We saw the health and safety audit had identified where some improvements were needed and these had been followed up. However, the audit had failed to identify water temperatures had not been taken in two of the three bathrooms in the home and that although the water temperature in the one bath tested in September 2016 had been recorded at a low level of 38°C on one occasion and 40° C on another, no checks had been made of this throughout October 2016. The registered manager told us only one of the bathrooms was used; however staff said two of the three bathrooms were in use. Not keeping a check on water temperatures, particularly in bathrooms can put people at risk of bathing in temperatures too hot or too cool to ensure their safety and comfort.

The registered manager and deputy manager had been informed by the local authority safeguarding team of the concerns raised about safe moving and handling in relation to the two people who required the use of a hoist. Yet we found no action had been taken to resolve these issues. For example, both people were accommodated in small bedrooms where space was restricted when using a hoist. There were larger bedrooms available which were vacant yet no thought had been given to offering these rooms to people. Similarly, staff were continuing to take these people to toilets which were not suitable to be used with a hoist as there was insufficient space. Care plans and risk assessments were not clear about what equipment

should be used or when to ensure these people were moved safely. This placed both people who used the service and staff at risk of injury.

The fire and laundry audit included the checking of fire doors. However, it had not identified what we found which was many of the bedroom doors, all of which were fire resistant and self-closing, were not closing properly. This potentially put people at risk in the event of a fire. The fire risk assessment said the doors to the kitchen were self-closing and had notices on stating they should be kept shut. However, we observed the fire door to the kitchen was propped open with a wedge for most of the day and the fire door to the office area was held open with the fire extinguisher. Following the inspection the deputy manager informed us the handy person had checked and adjusted all the fire doors so they closed properly.

The accident and incident audit was limited as it did not include the number of accidents that had occurred or identify any themes or trends so action could be taken to reduce the risk. The number of accidents occurring to individuals were not considered or analysed to make sure appropriate action had been taken in response to increased risk.

The food and nutrition audits did not include audits of food and fluid charts or the weight charts and had therefore failed to identify that both were poorly completed, inconsistent and at times inaccurate.

Care plan audits had been completed and actions identified, however they had not identified where risk assessments had not been completed and where information was not up to date.

We saw an infection control audit of the service had been completed by the local infection control team with a high score of 96% achieved. The deputy manager told us they had put new systems in place following this audit. For example, a better system for cleaning mattresses had been adopted on the advice of the infection control team. However, we found the clinical waste bin in the upstairs bathroom was not foot-operated which meant staff had to lift the lid with their hands which increased the risk of spread of infection. In another bathroom there was no bin provided which meant there was nowhere for staff to dispose of clinical waste items or paper towels when they had washed their hands. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.