Cheyne Group Management Limited

Cheyne House Nursing

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 January 2017 and was unannounced.

Cheyne House Nursing is registered to provide accommodation and nursing and personal care for up to 26 older people or people living with dementia. There were 15 people living at the service on the day of our inspection.

We carried out an unannounced comprehensive inspection of this service on 2 July 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook a focussed inspection on 30 June 2016 and 1 July 2016 to check that they had followed their plan and to confirm that they now met legal requirements. Breaches of legal requirements were found. Following this inspection we imposed conditions on the registered provider. These conditions meant that the provider was required to take specific actions to improve the service and meet legal requirements.

We undertook a focussed inspection on 23 August 2016 following information received about concerns to check that the provider had taken action with regard to issues raised by ourselves and other agencies who commission care for people living at the service. We also wanted to confirm their progress against conditions of registration which were put in place following the inspection in June and July 2016 met legal requirements. At our inspection on 23 August 2016 we found that the provider continued to be in breach of the regulations and had not made sufficient progress against the conditions of registration we had put in place.

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and breaches in Care Quality Commission (Registration) Regulations 2009. The provider had not ensured that people were kept consistently safe from the risk of harm or neglect, that people were provided with person centred care, did not follow safe recruitment practices, there were weaknesses in monitoring the quality of the service and the provider did not display their ratings from their last inspection.

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

The provider did not follow safe and effective recruitment procedures and did not ensure that all safety checks had been made. Fire safety evacuation plans put people and staff at risk of harm in event of a fire. We found that infection control practices had improved and people were now cared for in a clean environment.

Staff did not always have the knowledge and skills to provide people with effective care that met their care needs. Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, staff did not follow the correct procedure when a person was unable to consent to their care and treatment. People received a balanced and nutritious diet and drinks and snacks were provided between meals.

People were cared for by kind and caring staff. Care plans were not always person-centred and people were not involved in planning their care.

There was poor communication between staff and the registered manager that resulted in people not always receiving appropriate care in a timely manner. Activities provided to people did not reflect their interests and pastimes.

The provider did not ensure that the audits undertaken reflected the care that people received and there was no follow up to check that identified actions had been completed.

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

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 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.

People were not protected from the risk of avoidable harm.

Fire safety plans did not fully protect people.

The provider did not follow safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not use the training they had received to carry out their roles effectively.

Staff did not follow correct procedures when obtaining consent from people who lacked the mental capacity to give their consent.

People received a balanced and nutritious diet.

Is the service caring?

Requires Improvement

The service was not always caring.

People were cared for by kind and caring staff.

People were not involved in planning their care.

Is the service responsive?

Inadequate

The service was not responsive.

The care people received was not always person centred.

People were not involved in activities that reflected their interests and pastimes.

Is the service well-led?

Inadequate

The service was not well-led.

The systems to measure the quality of care provided did not lead to improvements in the service.

The provider did not display their rating from their last inspection.

The provider did not ensure that staff kept accurate records.

Cheyne House Nursing

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.

The inspection took place on 4 and 5 January 2017 and was unannounced. This inspection was completed to check that improvements to meet legal requirements had been made. We also looked at the progress the provider had made against the conditions of registration which we had put in place following our inspections on 30 June 2016 and 4 July 2016.

The inspection team was made up of one inspector and an expert by experience on day one of our inspection and two inspectors on day two of our inspection. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection we looked at previous inspection reports and we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. We used this information to help plan our inspections.

We looked at a range of records related to the running of and the quality of the service. This included staff training information and staff meeting minutes. We also looked at the quality assurance audits that the registered manager and the provider completed which monitored and assessed the quality of the service provided.

During our inspection we spoke with the provider, the registered manager, two registered nurses, two housekeepers, two members of care staff, the cook and the activity coordinator. We also spoke with five people who lived at the service and one visiting relative. In addition, we observed staff interacting with people in communal areas and providing care and support.

We looked at the care plans and daily care records for ten people and medicine administration records for five people. A care plan provides staff with detailed information and guidance on how to meet a person's assessed social and health care needs. In addition, we undertook a Short Observation Framework for Inspection (SOFI) in the dining room on day one of our inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We asked the local authority and commissioners of healthcare services for information in order to get their view on the quality of care provided by the service.

Inadequate

Is the service safe?

Our findings

At our inspections in June 2016 and August 2016 we found inconsistencies in staff knowledge and understanding of how to recognise that people were at risk of harm and how to share their concerns when a person was at risk of harm.

Since our last inspection the registered manager had introduced daily checks of the environment. However, we found that there were areas of risk that required action. For example, only one person had their bedroom on the first floor. The other bedrooms had either ongoing maintenance work to water damaged walls and ceilings or they were being used for the storage of mattresses, hoists, chairs and wheelchairs. The provider had not undertaken a risk assessment for this person to remain upstairs on their own at night and they were at risk of harm if they entered the vacant bedrooms. In addition, there were no risk assessments to establish how this person would be supported if they required urgent care as staff were not situated on this floor.

We found that fire safety and evacuation procedures put people who lived at the service and staff at risk of harm. People did not have a personal emergency evacuation plan with a detailed risk assessment of how to safely evacuate them from the premises in the event of an emergency situation. We found that there were two different notices on display throughout the home with conflicting information about actions to take in the event of the fire alarm sounding. One fire door was impassable with a wheelchair or evacuchair due to a freezer stored in this area. Another fire door had a plant pot in front of it. We were concerned that these obstacles would slow down an evacuation procedure, therefore putting people and staff at risk of harm. We brought this to the registered manager's attention and the plant pot was removed. Following our inspection we informed Lincolnshire Fire Safety Service who conducted an unannounced inspection on 10 January. They found further areas of risk and made recommendations to the registered manager to improve safety.

We found further evidence that people were at risk of harm in the event of a fire or other major emergency situation. On the morning of day one we spoke with the registered nurse in charge on night duty who informed us that they did not know where the business continuity plan was kept. This would compromise the safe evacuation of people from the premises. When we did see a copy of the plan we noted that the information was out of date and did not accurately record the names of the current management team or the people who lived at the service. These inaccuracies could lead to delays in securing extra staff to support with an emergency situation.

People did not receive care in a way that protected them from the risk of harm. At our previous inspections we identified that registered nursing staff did not always recognise signs when the condition of a person's skin was deteriorating or when they were at risk of developing pressure damage. Also, staff did not make timely referrals to the appropriate healthcare professionals to seek support and advice.

At this inspection we found that there continued to be poor management of a person's skin to reduce their risk of developing pressure damage. Although people had their risk of developing pressure damage assessed, and care plans were in place, we found that care plans did not always reflect their needs or staff

did not follow their plan of care appropriately and consistently.

We looked at the care plans, daily care logs and position changing charts for three people who at the time of our inspection had pressure damage. We found that two people had developed pressure damage since their admission to Cheyne House and a third person had been admitted to the service in 2015 with pressure damage and the painful condition of their skin had not improved. We saw that when a person's plan of care was amended to reflect the deteriorating condition of their skin that staff failed to follow their amended care plan and continued to put people at risk of further harm.

The provider was not analysing incidents and accidents to ensure that learning from these reduced the risk of harm to people living at the service. Action was not being taken to prevent repeat incidents. For example, we looked at the accident book and saw that one person had pulled their chest of drawers over them and injured their nose. The registered manager was not made aware of this and there was no risk assessment or care plans to reduce the risk of a further incident. At the time of our inspection the chest of drawers had not been made safe. Care staff told us that there was a risk of further incidents as this person liked to put away their own clothes in their chest of drawers and would pull their wheelchair up close to them. There was a high risk of this accident happening again.

The above issues were a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files for four members of staff and found that the provider did not always follow safe and effective recruitment practices. For example, we saw that one registered nurse had been appointed in the previous 12 months with only one reference and that their previous employer had not provided a reference. We also found that there were no interview notes on their file. The registered provider told us that they would forward the interview notes to us on day two of our inspection but we were not provided with them.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspections in June 2016 and August 2016 we found that registered nurses did not have the necessary skills and competencies to order, store and administer medicines safely. We asked the provider to ensure that registered nurses had their competency to manage medicines safely assessed and were provided with the training, supervision and support to maintain their competency. On this inspection we found that improvements had been made and medicines were ordered stored, administered and disposed of safely.

We looked at medicine administration records (MAR) for five people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was offered pain relief but declined to take it. When a person was prescribed medicine through a skin patch, a body map was in place and identified the areas where the patch was to be applied, to minimise the risk of damage to the person's skin. We saw where a person received their medicine covertly; that is mixed with their food that all necessary checks had been completed and staff had involved their GP and pharmacist and had acted in the person's best interest.

On day one of our inspection we observed medicines being administered to people at breakfast and at lunch time and noted that appropriate safety checks were carried out and the administration records were

completed accurately. However, the registered nurse did not follow best practice and did not take the medicine trolley to people in their bedrooms. Instead, the registered nurse dispensed medicine from the trolley in the dining room and carried the medicine in an open plastic pot to people in their bedrooms. There was a risk that a person living at the service or another member of staff could collide with the registered nurse in the corridor and the medicines may be spilled from the pot. Also, if a person in their bedroom requested an as required medicine the registered nurse then had to walk back to the trolley to administer the medicine, we observed that this caused a delay in the person receiving their medicine in a timely manner.

At our previous inspections we found that the provider did not ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff and was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that there were sufficient numbers of staff on duty and the provider was no longer in breach of the regulation.

Although there were enough staff on duty on this inspection we were concerned that there were times when staff were unavailable to look after people's needs or check that they were safe. For example, we sat in on the morning handover at 7.30am on day one of our inspection. We found that there was no overlap between shifts to allow for handover. The night care staff had gone home and the night registered nurse handed over to the registered nurse and care staff who had just come on duty. The handover was conducted in a lounge at the front of the premises away from people's bedrooms and toilets. The only other member of staff on duty in the home at that time was the cook who preparing lunchtime meals in the kitchen. The night registered nurse delivered the handover in their own time.

The provider completed a dependency tool for each person who lived at the service to calculate the amount of staff and the skill mix of staff needed on each shift. People were given a score from nought to five for individual activities of living such as breathing and dressing. However, we found that their calculated score did not respond to their care needs. For example, nine people were identified on the dependency chart as having deep pressure ulcers and scored five. However, there were only three people living in the service at the time of our inspection with pressure damage.

At our inspections in June 2016 and August 2016 we found a continuous breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People that lived at the service and staff were at risk from damaged equipment and furniture. There were no systems in place to monitor the safety of equipment and to report items in need of repair. At this inspection we found that the provider had taken action to meet the legal requirements and was no longer in breach of the regulation.

We found that there was now a maintenance person in post to manage repairs and decoration. There was a system in place for staff to report damaged and broken equipment. We observed that some areas of the service had been decorated or had worn or damaged flooring replaced. We saw that some bedrooms downstairs were in need of re-decoration. The register manager told us that there was an ongoing programme of refurbishment.

At our inspections in June 2016 and August 2016 we found that several areas of the service were not clean and this put people and staff at risk of cross infection. The provider has since employed a new housekeeping team. On this inspection we saw that improvements had been made. For example, the laundry and sluice were clean and free from clutter and staff had access to and wore protective equipment such as plastic aprons and gloves. Cross infection is when one person transfers their germs to another person or germs are transferred from equipment to a person however we saw some examples of poor practice such as a staff member carrying an open commode which created a risk of urine being spilled and incorrect use of

protective clothing.

Requires Improvement

Is the service effective?

Our findings

At our inspections in June 2016 and August 2016 we found that staff did not have the competencies and skills to perform their roles effectively. One of the conditions of registration that we imposed on the provider in August 2016 was that all registered nursing staff had their competence to practice safely assessed and receive appropriate training where weaknesses were identified. Prior to our inspection the provider told us that all nursing staff had been assessed as competent.

On this inspection we looked at staff training records. It was recorded that all staff were up to date with all mandatory training since our last inspection. However, we did not see evidence of this in practice. For example, some staff could not tell us what they had learnt about Mental Capacity Act 2005 (MCA), consent, or how to report safeguarding concerns to professional bodies outside the provider organisation. On this inspection we found that although all staff had received training in safeguarding vulnerable adults and registered nurses had been assessed as competent to carry out risk assessments that there continued to be areas of concern with nursing and care staff.

At our inspections in June 2016 and August 2016 we found that people's consent to care and treatment was not always sought by staff and staff did not follow the guidance laid down in the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that 14 applications to lawfully deprive a person of their liberty had been submitted to the local authority and were approved and a further authorisation had been refused because the person had capacity to make the decision to live at the service. Although the provider had taken action to address the breach of Regulation 13 by submitting applications for DoLS, we found that they still did not fully understand the requirements of the MCA in ensuring that decisions were made in people's best interest and ensuring that people were able to consent to their care and treatment. For example, we saw that some people who lacked capacity to consent to aspects of their care or treatment had appointed a Lasting Power of Attorney (LPA). However, staff did not apply the LPA appropriately for two people who lacked capacity to consent to care and treatment. We found that their relatives were LPA for property and finances only, rather than health and welfare and had signed on behalf of their loved ones consent for bed rails and to their plan of care.

This was a continuous breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspections in June 2016 and August 2016 we found that the provider did not always ensure that people's nutrition and dehydration needs were met and there was poor communication between the registered nurses, care staff and the cooks about individual nutritional needs. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had taken action to make improvements and meet the legal requirements and was no longer in breach of the regulation.

People were now provided with a well-balanced and nutritious diet. Hot and cold drinks and a biscuits or a piece of cake were offered mid- morning and afternoon. The lunchtime menu was written on a chalk board, and photographs of the main dishes were on display in the dining room. We saw where one person could not remember what they had chosen for lunch that a member of staff brought two plates of food to help them make their decision. One person, who preferred to spend much of their time in their bedroom, told us that they liked fresh fruit and said, "We could do with more fresh fruit. We ought to have a little bowl of fruit in our rooms, that would be nice wouldn't it?" We saw that there was a glass fronted information board with national guidance documents on eating well on display. However, people and their relatives could not access the guidance as it was locked behind glass.

We spoke with the cook who told us that improvements had been made to the dining experience since our last inspection. There was now a record of people's individual food likes and dislikes and alternatives to the main menu were available. The cook said, "The menus don't need to be rigid; give people what they want." We found that when a person had difficulty swallowing and had their meals pureed that all food ingredients were presented separately and had been moulded into the shape of the food and their meal looked appetising. The cook had guidance from the speech and language therapist on the consistency of special diets for people with swallowing difficulties. All the staff we spoke with said that the food had improved.

At our inspections in June 2016 and August 2016 we found that the provider had not ensured that people who lived at the service received timely referrals for professional healthcare advice, treatment and support. On this inspection we found evidence that staff had improved their communication with healthcare professionals and a record of all communication was kept in the person's care file. We observed that when a person needed medical assistance the registered nurses contacted the person's GP or emergency out of hours service. For example, one person complained of pain in their legs at breakfast time and told the registered nurse that their current medicines did not ease their pain and said, "I'd like to see the doctor again." The registered nurse contacted the medical practice and requested a review of the person's pain relief. The registered nurse said, "When we ring GPs and ask for a visit they don't come, but prescribe over the phone or will only discuss with the manager." We discussed this with the provider and registered manager. The provider said that they were building an improved relationship with the local medical practices.

We found that improvements had been made to the frequency, content and recording of supervisions and appraisals since our last inspection. We looked at supervision records and saw that there was a set theme each month. For example, mental capacity. A registered nurse shared their experience of receiving and facilitating supervision sessions and said, "I like to keep them up to date. You need to get feedback; you need to know what to do better."

Requires Improvement

Is the service caring?

Our findings

Some people told us that they liked living at the service and were well cared for. One person said, "It's a nice place to be here. They are nice people. I like the people who look after me. They look after me well. The staff are smashing." Another person told us, "I think the staff are polite and respectful." One person's relative told us that staff treated their loved one with dignity and respect.

We saw that most people's bedrooms were personalised with items from home such as family photographs and small keepsakes. However, on both day one and day two of our inspection we found that most downstairs bedrooms had their bedding removed. We were informed that the bedding was being laundered and the beds would be remade later in the day. We were concerned that this did not give people the choice if they wished to return to their bedroom to rest on their bed. The provider did not ensure that tasks were completed in such a way that ensured people had choice in their daily lives.

We saw that systems that had been put in place to support people with memory or cognitive difficulties had not been maintained. Near the front entrance to the service there was a board with photographs of staff members. However, this had not been kept up to date and some of the photographs on the board were of staff who no longer was employed by the service. This could be misleading to people assessed as disorientated to their surroundings. We also found that most of the clocks in public areas and in people's bedrooms did not work. One person had three clocks in their bedroom and none of them worked. This would confuse people living with dementia as they may be unable to know what time of day it was. This could result in them becoming disoriented and in turn agitated or distressed.

The provider did not ensure that there was clear signage throughout the service. All the bedroom doors looked the same and although they were numbered and had the person's name, on them they did not have a photograph of the person to help their recognition. There was a risk people could become disoriented with their surroundings.

We looked at the care plans for 10 people and saw that although registered nurses had reviewed them on a monthly basis there was no recorded information on how the person receiving care had been involved in their reviews.

On day two of our inspection we observed the maintenance person help to personalise one person's bedroom by hanging model planes from their ceiling. Another person had greetings cards and photographs hanging from their ceiling so as they could see them when lying in bed.

We observed staff assist some people to the dining room for their lunch. People were supported to walk at their own pace and staff chatted with them in a friendly manner. We observed small acts of kindness, for example one person's spectacles were dirty and a member of staff cleaned them so as the person could see

clearly to eat their breakfast. The hairdresser had visited on day two of our inspection and we overheard a member of staff compliment one person on having their hair done and their nails manicured. The person enjoyed the attention the staff member gave them.

We saw that the provider's dignity promise and philosophy of care were on display in the main corridor. However, it was placed high on the wall and would be difficult for people dependent on a wheelchair to read.

Staff could tell us how to maintain a person's dignity when delivering personal and intimate care. One staff member said, "If we're washing them, keep them covered up. Keep their privacy, not too intruding; we work in the place they live." Although all staff had recently received training about maintaining people's dignity, we observed that staff did not always behave in a dignified way in front of people who lived in the service. For example, at lunchtime, we overheard care staff talk about one person's deteriorating condition in front of other people in the dining room.

We saw that one person had a lay advocate to assist them with decisions about paying for their care and accommodation. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

Inadequate

Is the service responsive?

Our findings

We saw that people had their needs assessed and care plans addressed those needs. However, we found that the plan of care was not always followed in practice; the care people received was not person centred but was structured around tasks to be delivered. For example, one member of care staff told us, "People are looked after very well. We have a duty of care to them; fed, watered, dry, turned, clean clothes, bath or shower." The also shared that there was a bed linen change rota and a bathing book, but that they tried to "give them what they want."

We saw further examples of failure to follow through care plan instructions. For example, we looked at one person's care file and read that prior to 17 July 2016 their care plan stated that they required their blood sugar levels to be monitored and recorded four times a day. On 17 July 2016 their care plan was amended and recorded that they were to have their blood glucose monitored twice a day. Their medicine administration record identified that in the seven days preceding our inspection their blood glucose had been monitored three or four times a day. We found no recorded evidence in the care files to support the increase in the blood sugar monitoring. This procedure is painful and can cause damage to a person's fingers and nerve endings.

We observed one person who spent much of their time walking about the service. They entered other people's bedrooms uninvited and most of the time carried a soft toy. There was little evidence that staff supported this person to be involved in meaningful activities. We found that the person enjoyed spending time with their doll and soft toys. However, we saw that most of their soft toys were out of their reach on a high shelf in their bedroom. They also had a pram in their room, but staff did not support the person to use their pram.

We asked care staff how they knew what care people required or how they liked to spend their time. We found that staff did not understand the significance of reading a person's care file. One member of care staff who had worked at the service since July 2016 told us, "It's all in the care plans, but we [care staff] don't deal with them. We can read them if we want to, but I haven't as no reason to really." We asked them to be more specific about how they knew an individual person's care needs and they replied, "I know their care by daily tasks. You get to them by their turning, hygiene, food and fluid charts." This meant that people may not receive care their care as planned. People were supported by an activity coordinator. We saw that the activity co-ordinator engaged several people during the afternoon in an armchair ball game in one of the lounges. However, they were unavailable to support people with activities on the morning of day one as they were escorting one person to an outpatient appointment. There were suitable numbers of staff on duty to care for people, but the registered manager had not allocated staff to support people in hobbies and pastimes.

Although we saw that there were some activities for people who lived at the service, individual's interests were not always considered or recorded. For example, we spoke with one person in their bedroom who told us that they loved classical music and piano music. However, they added that they did not know how to listen to their music on a compact disc player. One of the inspection team assisted the person to play their

music. The person's mood immediately changed and they began to sing along to the music and chatted about their earlier life and their relative who was a famous composer and conductor. We brought this person's love of music to the attention of care staff. We looked at this person's care file and saw that their family had recorded in the "life history" section that they liked live music. However, there was no reference to this or any other musical preferences in their care plan.

We asked care staff if they would live in the service or recommend it to family and friends and one member of staff replied, "Would I like to live here? No. They come into a building and never leave it. That is a scary thought." The staff member then told us that people had very little to do and were bored and said, "They need more activities and trips out. Must be boring to be sat all the time. We don't have much chance to sit and chat. People need our assistance and take up our time."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a suggestion box at the main entrance for people and their relatives to give their thoughts on the service. However, it would be difficult for people who lived at the service to give their comments as they did not have access to this area.

A copy of the complaints policy was available in the main corridor and guidance on how to make a complaint was included in the service user guide. One person's relative told us that they would approach the registered manager with concerns and said, "If there is ever anything I want to say, I just go to the manager and it's sorted there and then. She is very good, but there is never anything to quibble about though." One person who lived at the service said, "I'm lucky. I don't have any worries, so I don't have to go to anyone."

We noted that four complaints had been received in the last six months and these had been addressed and resolved by the registered manager in a timely manner as per the provider's guidelines.

Inadequate

Is the service well-led?

Our findings

At our previous inspection identified that the provider did not operate effective processes to make sure that they assess and monitor their service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In August 2016 we put conditions on the provider's registration to assist the provider to improve the service. However, when we checked their progress on this inspection we found that they had not made sufficient progress.

We found several shortfalls in key documents. The statement of purpose (SOP) did not reflect current best practice guidance and legislation. For example, the provider made reference to National Minimum Standards and Primary Care Trusts which are now obsolete. This meant that the information was out of date and may not accurately reflect the purpose of the service. A SOP sets out the aims and objectives of the service and how the provider will meet the needs of the service.

The registered manager had undertaken audits since our inspection in June and August 2016. However, these were not always effective and there were no action plans or a record of what had been resolved. On 2 January 2017 the registered manager completed an infection control audit. We saw that they had scored themselves as having achieved 100%. However, our observations on day two of our inspection contradicted this result. We witnessed a member of care approach a person who was calling out for help to offer them assistance. The staff member was wearing a blue apron. The intended use for blue aprons was for kitchen purposes only and not to be worn when delivering care. We brought this to the registered manager's attention who asked the staff member to remove the apron. The carpet in one occupied bedroom was heavily soiled. We brought this to the registered manager's attention and they said they would request a deep clean of the room. We observed a member of care staff leave a person's bedroom carrying a commode basin containing urine. The inspector asked why it was not covered and was informed by the staff member that there were no commode basin covers in the service. The registered manager was unaware of this. This posed a risk of cross contamination if the contents of the commode basin were spilled onto a resident, a member of staff or visitors to the home. This meant that although the registered manager had undertaken audits, they had not identified these areas of poor practice.

The provider had introduced a programme for staff and resident meetings. We looked at the minutes from a staff meeting held on 15 December 2016 which was attended by nine staff. Topics for discussion included an imminent CQC inspection and the death of a person from tissue damage. Staff were expected to sign the minutes when they had read them, and we noted that two out of the nine staff who attended the meeting had done so and there was no evidence that staff who were unable to attend the meeting had read the minutes. This meant that there was no assurance that lessons learnt from the death of a person who had acquired tissue damage when they lived at the service had been shared with all the care team to reduce the risk of another death from the same cause. The meetings scheduled for August and September had been cancelled. We asked care staff if they found the staff meetings beneficial. One staff member said, "Not much gets said, [name of registered manager] says what they want to say. Not many turn up. Night staff don't come." We read the minutes from the cooks' last meeting on 22 August 2016. The new menus were

discussed and planned. We saw no evidence that people who lived in the service had been involved in planning the menus. However, we did see recorded in the minutes from the "residents" meeting held on 14 October 2016 that people had been asked for their feedback on the menus and if there were any foods they would like to add. There was no record of relatives meetings since June 2016. However, we did note that the suggestions for improvement that relatives made at that meeting had not been achieved. For example, relatives had requested new patio furniture, raised flower beds that people could access and a clock and a date board in the two lounges.

There was no method of assessing staff training, to monitor if their competency assessments were effective or how their training led to improvements in practice. For example, one registered nurse had completed training for safe moving and handling and had had their competency assessed since our inspection in August 2016. On 6 December 2016 they were in charge of the shift and one person in their care had a fall in the patio area. A visiting health care professional observed the registered nurse perform an unsafe moving and handling technique to assist the person off the ground and noted that the registered nurse did not assess the person's injuries before moving them and the person was treated for a head injury at the local accident and emergency department. Furthermore, the registered manager did not take appropriate action to investigate the incident until they were requested to do so by the local authority safeguarding team.

Prior to our inspection the provider submitted a residential care pre-inspection information pack (PIR) to the commission at our request. The PIR did not reflect what we already knew about the provider or found on this inspection. The provider had recorded that there had been one medicine error in the last 12 months. However, our inspections undertaken on 30 June 2016 and 23 August 2016 both identified numerous medicine errors. These errors included the registered nurse not taking the medicine trolley to people in the downstairs bedrooms, but administering them in the conservatory and carrying them in open medicine pots to people in their bedrooms and failure of the registered nurse to supervise people taking their medicines and instead leaving them on their bedside table. At this inspection we found that these practices were still ongoing.

A PIR provides the provider or registered manager with the means to tell us what they are doing well and what improvements they plan to make to the service in the next 12 months. We found that the provider did not have systems in place to identify ongoing improvements to make the service safer. The supporting information in the PIR, submitted on 5 December 2016, did not provide sufficient information about what the service had achieved since our last inspection or what improvements the provider planned to make in the next 12 months. For example, in response to "What improvements do you plan to introduce in the next 12 months that will make your service safer, and how will these be introduced," the provider had responded, "We don't anticipate any major improvements as we have undergone drastic improvements over the last 6 months."

The registered manager provided us with their investigation notes for the one medicine error reported on their PIR. A registered nurse failed to supervise one person take their 9am medicine. At 11.30am a member of care staff brought this to the registered manager's attention as they had found the medicine on the dining room table. There was a risk that other residents could have taken this medicine and it could have been harmful to them. This error occurred when the registered nurse was having their competency assessed to administer medicines safely to people in the service. We have concerns that the registered manager who was the assessor did not have the necessary competency to undertake the assessment of the registered nurse as they were unaware of the error until it was brought to their attention.

We looked at the completed medicines competency assessment record for the registered nurse. The assessment record was divided into different competencies sections with a multiple choice tick box

answering system. There was a section on, "Demonstrates an awareness of the local policies" and the registered manager has ticked the answer, "consistently meets criteria." Their response indicates that there were no errors observed during the assessment and that the registered nurse had complied with their policy. Another section stated, "Appropriately applies NMC and care standards guidelines." The registered manager has ticked the answer, "meets criteria but would benefit from further training." The registered manager's responses do not clearly reflect what actually occurred when the registered nurse had their competencies assessed administering medicines. There was no record that the registered nurse had made an error during the competency assessment. The registered manager informed us that they had not shared this incident with the Nursing and Midwifery Council (NMC); although they were aware that the registered nurse was being monitored by the NMC at that time. The Nursing and Midwifery Council is the professional body responsible for regulating that registered nurses are fit for practice.

There were systems in place for staff to have link nurse duties and buddy roles however these were ineffective as staff were unaware who had link nurse duties or if they were allocated a link nurse or buddy role. One registered nurse told us that they were the lead nurse for Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, they were unable to tell us how they would execute their role. A member of care staff told us that they also had a lead role and said, "I have a lead role. I couldn't tell you what it is. I couldn't tell you anything about it." Two notice boards with link nurse information were inconsistent and had out of date information. For example, staff who no longer worked at the service were listed as having link nurse or buddy roles. Link nurses and buddies act as a resource to their colleagues and can direct others to national guidance, policies and care pathways on the subject of their buddy or link nurse role.

We found that there was evidence of weaknesses in the provider's systems to support communication between members of care staff, registered nursing staff, registered manager and the relatives of people who lived at the service. This lack of communication impacted on the overall wellbeing of individual residents. For example, the registered nurses did not pass on the deterioration in the health of one person. On day one of our inspection one of the inspectors observed the morning shift handover. It was passed from the night duty registered nurse to the day duty registered nurse that the person had been unwell the previous evening and had been seen by two community nurses from the emergency care team. The visiting nurses told the registered nurse on duty that the person was at the end of their life and not to receive any active treatment. We looked at the person's care file and saw that their GP had visited them the previous week and it had been recorded that they were not for active treatment and to monitor and maintain their wellbeing. There was no record that their family had been informed or that palliative care specialist nurses had been contacted for advice on end of life care and support for the person, their family and nursing and care staff. Furthermore, the person did not have an end of life care plan and their GP had not been approached to prescribe pre-emptive medicine to reduce the risk of distressing symptoms such as pain and nausea at the end of their life. We shared our concerns about the management of the person's care with the provider and registered manager and they were unaware of the person's health status.

One of the conditions imposed on the provider in July 2016 was that they must ensure that all registered nursing staff, care staff, housekeepers and catering staff employed in the care and welfare of service users are competent in keeping accurate records. On this inspection we found gaps in position change charts and night time records.

Staff told us that there was a bullying culture in the service. For example, they said the provider had told staff that if CQC inspectors ask them anything they were to tell the inspectors that they were happy working there and the provider gave them a free meal. We read the resignation letters from two registered nurses who had recently resigned. One of the reasons they had given for leaving their role was because the provider had

bullied them. One member of staff told us, "After the last inspection [name of provider] looked at the rotas to work out who was on duty and who had said what." Another staff member said that the provider had threatened to sack staff who had spoken out. Another member of staff said of the provider, "I'm not sure about him. He has a bit of a temper." They also told us on day one of our inspection that they had been asked by the provider to stay on duty passed their finishing time because the inspectors were in the service. The staff member agreed to do this, although the provider did not offer to pay them for their time or give them the time back at a later date.

The above issues are a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One condition of the provider's registration is that they display the ratings from our last inspection of the service. We noted that the rating from our last inspection was not on display. The provider and registered manager told us that the reason for this was that one person who lived at the service since May 2016 had removed the ratings and other important information from the notice boards. No action had been taken by the registered manager or the provider to attach notices securely to information boards.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspections in June 2016 and August 2016 we found that the provider did not notify us when a person who lived at the service had died. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had taken action to notify us when a person in their care died and was no longer in breach of the regulation.

At our inspections in June 2016 and August 2016 we found that the provider did not notify us when a person who lived at the service had a deprivation of liberty safeguards authorisation granted. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had taken action to notify us when a person in their care had a deprivation of liberty safeguards authorisation granted and was no longer in breach of the regulation.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (3) HSCA (Regulated Activities) Regulations 2014 Person-centred care. The registered person did always provide people with care that was appropriate and met their needs.

The enforcement action we took:

Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) The provider did not ensure people received safe care and treatment.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (4) (d) HSCA (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. The registered person did not ensure that the Mental Capacity Act 2005 was used appropriately.

The enforcement action we took:

Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) HSCA

Diagnostic and screening procedures Treatment of disease, disorder or injury	(Regulated Activities) Regulations 2014 Good governance. The registered person did not have systems in place to assess, monitor and improve the quality of care to people.

The enforcement action we took:

Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (1) (b) (2) (a) (3) (a) (b) HSCA (Regulated Activities) Regulations 2014 Fit and proper persons employed. The registered person did not follow safe recruitment practices and ensure people in their employ were fit and proper persons.

The enforcement action we took:

Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments Regulation 20A (1) (3) HSCA (Regulated Activities) Regulations 2014 Requirement as to display of a performance assessments. The registered person did not display the performance rating from their last inspection.

The enforcement action we took:

Notice of proposal to cancel registration.