Larchwood Care Homes (North) Limited

Sowerby House

Inspection report

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13 October 2016
14 October 2016
19 October 2016

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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 over three days on 13, 14 and 19 October 2016 and was unannounced. The service was previously inspected in February 2015 and at the time was meeting all regulations assessed and was rated 'Good'.

Sowerby House Nursing Home is registered to provide residential and nursing care for up to 51 older people some of whom are living with a dementia. At the time of this inspection, 27 people were living at the service 11 people were receiving nursing care and 16 people were receiving residential care. We were told that one person, receiving residential care, was in hospital.

The service did not have 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.

The inspection was prompted in part by the notification of two separate concerns following the deaths of two people living at the service. The Coroner had asked North Yorkshire Police to conduct a review of the deaths. These incidents are currently being assessed by the police to determine any levels of criminality. As a result this inspection did not examine the circumstances of these incidents.

However the information shared with CQC about the incidents indicated potential concerns about the management of people's nutrition and hydration and general standards of care. This inspection examined these issues.

At this inspection we found that there were breaches of six of the Fundamental Standards of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, nutritional and hydration needs, consent, safeguarding, staffing and the overall oversight and governance of the service.
Also, there was a failure to meet the requirements of the Care Quality Commission (Registration) Regulations 2009 regulation 18 - notification of other incidents and a breach of the provider's conditions of their registration – the requirement to have a registered manager.

The registered provider had failed to ensure all of the people who used the service had received safe and effective care and treatment. We found they had not taken reasonable and practicable steps to mitigate the risks posed to people who used the service.

Because of our concerns about people's care and treatment during the inspection, we made 12 individual safeguarding referrals to North Yorkshire County Council. We will monitor the outcome of these investigations.

The service did not have sufficient numbers of skilled and competent staff to meet people's needs. There was a lack of nursing oversight and the service was reliant on agency nurses which meant people's clinical care needs were not sufficiently met.

Medicines were not being safely administered in line with prescribing instructions.

People's nutritional and hydration needs were not being met and there was a lack of oversight or monitoring to ensure people received the support they needed.

The service was not following the principles of the Mental Capacity Act 2005. We did not see consent recorded within people's care plans and when people were unable to give consent best interest decisions had not taken place. People were being deprived of their liberty without the required safeguards in place.

Care plans were difficult to follow; reviews were not up to date and did not consistently reflect people's current needs. They did not provide staff with sufficient detail to deliver person centred care. People's changing needs were not always responded to effectively.

The registered provider did not have effective systems in place to monitor the care being delivered to people. We found record keeping was poor and management oversight at the service was not effective in ensuring people were provided with safe care.

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 enforcement action, 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 and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures.

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.

Risks to people had not been adequately assessed. This meant people were not protected from avoidable harm.

11 individual safeguarding referrals were made to the local authority for further investigation.

Medicines were not safely managed and there were some concerns about the cleanliness of the service.

Systems in place to record and manage accidents and incidents and mitigate re-occurrence were ineffective.

The service did not have sufficient skilled and competent staff to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

People's nutritional and hydration needs were not always met.

Staff were inconsistent in the support they provided to people who required assistance to eat.

The principles of the Mental Capacity Act 2005 were not being followed.

People were being deprived of their liberty without the required safeguards in place.

Staff were not adequately supported and essential training had not been delivered.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care was not always centred on the person.

People were not assisted with their basic care needs which meant people were at risk from harm.

On the nursing unit, we saw people calling out for prolonged periods before assistance was provided.

People living on the residential unit told us their privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all care plans provided staff with sufficient detail to deliver person centred care. People's changing needs were not always responded to effectively.

People living on the residential unit told us they enjoyed the activities on offer.

People knew how to make complaints. We found that not all complaints had been recorded effectively.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and clinical oversight by the registered provider was not effective.

Systems in place were inadequate and did not ensure people who used the service were safe, received effective, caring and responsive services, which met their needs.

Systems and processes to manage and mitigate risks were inadequate to keep people safe from harm and abuse.

The registered provider had failed to submit statutory notifications in line with requirements of their registration with the Care Quality Commission.

Sowerby 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.

The first day of our inspection took place on 13 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist professional advisor who was a nurse and an expert by experience who had personal experience of using older people's care services.

The second and third days of our inspection were on 14 and 19 October 2016 and were announced. The team consisted of two adult social care inspectors on both days.

The registered provider completed 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.

Before our inspection, we reviewed the information we held about the service and information from meetings held with the local authority safeguarding and commissioners and the Clinical Commissioning Group (CCG). We were aware of a number of safeguarding investigations which were currently being investigated by North Yorkshire County Council.

Over the course of three days we observed the care provided to people who used the service. We spoke with 15 people who used the service, three relatives, the regional manager, peripatetic manager and another supporting manager who had worked at the service over the summer, three agency nurses, a senior member of care staff and five staff members including ancillary staff.

We also reviewed two staff records, 14 sets of care records, medication records and seven people's food and fluid records, as well as other records related to the management of the service.

Inadequate

Is the service safe?

Our findings

The inspection was prompted in part by the notification of separate concerns following the deaths of two people living at the service. The Coroner had asked North Yorkshire Police to conduct a review of the deaths. These incidents are currently being assessed by the police to determine any levels of criminality. As a result this inspection did not examine the circumstances of these incidents.

However, the information shared with CQC about the incidents indicated potential concerns about the management of people's nutrition and hydration and general standards of care. This inspection examined these issues.

Sowerby House Nursing Home has been in North Yorkshire County Council (NYCC) collective care, safeguarding procedures, since May 2016 and concerns have been raised in respect of the following areas; inadequate record keeping and care planning, documentation not being completed correctly, staffing levels, lack of staff supervision and training and general concerns regarding poor leadership within the service.

During the first day of our inspection we raised concerns, with the regional manager, about the safety of people receiving care on the nursing unit. The regional manager, who had been given permission to act on behalf of the registered provider, informed us of the registered provider's decision to de register nursing provision at the service. They told us this was due to an inability to recruit or retain nursing staff. The regional manager informed the commissioning manager at North Yorkshire County Council. This meant that people receiving nursing care needed to be urgently relocated to alternative nursing homes.

During our three day inspection we made 11 individual safeguarding referrals to NYCC. The concerns we identified related to a failure to meet people's basic care needs; lack of adequate food and fluid intake, an unexplained injury, medication errors, lack of appropriate risk management plans placing people at risk of harm.

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

Risks to individuals on the nursing and residential units had not been adequately assessed and risk management plans were not in place. This meant people were at risk of avoidable harm. For example, although some people were receiving pureed diets and thickened fluids no one at the service had a choking risk assessment or risk management plan in place. This meant staff were not provided with the guidance they required to ensure people were safely supported to eat and drink.

In addition to this a number of people had bed safety rails in place but there were no risk management plans in respect of the risks associated with entrapment or injury. On the final day of the inspection we were told that one person's bed rails had been removed as staff had told the supporting manager that the person had tried to climb over them. This meant the person had been at risk of injury but there had been no risk

assessment in place in relation to this. The supporting manager ensured this was in place before we left the service.

One person had sustained a fracture injury since when they had been unable to mobilise safely and required the assistance of two staff because they were unable to stand. We found their moving and handling care plan had been updated and referred to the need for a hoist. However, there was no risk assessment in respect of this. On reviewing the person's care file we found they had a medical condition which meant they were at high risk of sustaining fractures. There was no risk assessment or risk management plan in relation to this medical condition which meant staff were not provided with the guidance they required to ensure the person's safety. We asked the peripatetic manager to ensure these assessments had been updated prior to us leaving the inspection on the second day which they did.

When asked, the management team were not aware of this person's injury or how it had occurred. There was no accident or incident analysis from when the person returned from hospital. We reviewed the daily records and could find no evidence of a fall. This meant the injury was unexplained and we referred this to the local authority safeguarding team for further investigation.

We identified one person on the residential unit who was at risk of leaving the building and was unsafe to do so because of their dementia. There were two recorded incidents in August 2016 which involved this person being found outside the service. However, there was no information within the person's care plan to inform staff what signs to look for that this person may be becoming distressed or what techniques staff should use the try and alleviate any distress. Daily records indicated that the person should be observed more closely. However, there was no documentary evidence of these checks having taken place. We were told by a senior member of care staff that this person was no longer on increased observation. There was no information within the person's care plan or risk assessment with respect to their personal safety. Therefore, we could not be assured the identified risk was being adequately managed which meant the person had continued to be at risk of avoidable harm. We spoke with the regional and supporting manager regarding this concern and asked for a plan to be put in place before we left on the second day of our inspection.

One person had been assessed as being at a high risk of falling. They had been referred to the physiotherapist and a new walking aid had been provided. However, their care plan and associated risk assessment had not been updated to reflect this. On the first day of our inspection, we saw an electric panel radiator in use within their bedroom which was hot to touch. We were concerned at the risk of burns should the person fall next to the heater and alerted the risk to the peripatetic manager. This person had been assessed by the service as requiring a falls sensor mat and a call bell alarm. However, neither of these were plugged in when we visited the person's bedroom.

Accidents and incidents were not being recorded and analysed. For example, one person on the residential unit had 14 falls recorded in their daily notes from 1 August 2016 but there were only eight associated accident forms. This meant that the registered provider could not be assured that the management team within the service were aware of all of the incidents which had taken place within the service or indeed that they had taken the action required to reduce the risk of incidents recurring. Therefore, risks related to accidents and incidents were not being adequately assessed or managed and meant people remained at risk of harm.

Medicines were not safely managed. On the nursing unit there was a lack of clinical oversight in relation to people's medicines. This was because the unit was being managed by agency nursing staff. For example, we saw one person required specialist dressings to treat their leg ulcers. The service had run out of these dressings which meant the person had not received the treatment they required to keep them safe. Another

person was receiving pain relief via a patch which was placed on their skin. We saw this had not been changed every seven days as required. Following the inspection the regional manager informed us a safeguarding referral had been made as this person had been found to have two pain relief patches on. This meant the person was at risk of harm from an overdose of pain relief. In addition to this the staff did not use any recognised pain assessment tool so we could not be assured this person's pain was being adequately managed.
There was a lack of clarity regarding another person and their prescribed supplement drink. The Medication Administration Record (MAR) had been signed to say this should be discontinued. We saw a daily recording on 17 October 2016 advising this was no longer safe as the person was at risk of choking. Despite this the MAR showed this drink had been administered on 18 and 19 October 2016. The inspectors sought an urgent GP review for this person due to the potential risk of choking.

On the first day of our inspection, we found the morning medicines were still being administered at 12 noon on the residential unit. This meant we could not be assured that medicines were being administered in line with the prescribing instruction and that there was an adequate gap before the next set of medicines were administered. One person's MAR stated they required their medicines 30-60 minutes before food. On 14 October 2016, we observed this person was given their medicines. We then saw them eating their breakfast less than 30 minutes after their medicines were administered. This meant that care staff had not administered the person's medicines in line with the prescribing instructions.

Some people had been prescribed medicines 'as required' (PRN) but there were no protocols in place for staff to identify when these medicines should be administered. There were no 'as required' protocols or guidance for staff on either the nursing or residential unit. This meant we could not be assured people were receiving these medicines in line with the prescribing instructions.

The above findings meant that care and treatment at the service was not delivered consistently or safely. This was because we found risks to people were not adequately assessed. Medicines were not safely managed. Inspectors had to intervene and prompt the staff on duty to take actions to keep people safe. This meant people living at the service were at risk of harm which could have been avoided if the registered provider had taken the action required of them to mitigate these risks.
This was a breach of Regulation 12 (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

The service did not have sufficient numbers of suitably qualified, competent and skilled staff to meet people's needs. The nursing unit had been operating solely on agency nurses since 11 October 2016. The peripatetic manager was not a nurse and had only been at the service for four weeks. This meant there was no clinical oversight in respect of people's individual nursing care needs.

There were no night time senior care staff which meant the most senior person on shift was an agency nurse. They had to administer medicines across the whole service, as only two senior care workers had been trained to safely administer medicines. Neither of these staff worked overnight.

We identified some gaps in the staff rota over the four weeks prior to our inspection which showed the service had not met their own identified minimum staffing levels to enable them to deliver safe care. This included care and ancillary staff such as cleaning and laundry staff. A member of staff we spoke with said, "Staff do not have time to talk to people or look after them properly. People's call bells are not answered for ages because staff are busy with other people." One person who lived on the residential unit told us, "Most of the staff are quite nice but sometimes they are short of staff and there are not a lot of staff we can ask."

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

The service had effective systems in place to ensure people were recruited safely. Appropriate checks had been undertaken for new starters before staff began work; each had two references recorded and checks through the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

When we looked around the premises we found there was a strong odour of urine at different times of our inspection in the main lounge. We spoke with the peripatetic manager about the odour and were told they believed this was engrained in some of the lounge seating and carpets. They told us they were awaiting funding approval to have these replaced.

We made the regional manager, who was acting on behalf of the registered provider, aware of the multiple concerns we had during the course of our inspection.

Inadequate

Is the service effective?

Our findings

The service was not effective. People's nutrition and hydration needs were not being met. On the first day of our inspection we found three people on the nursing unit had not been supported to eat or drink until inspectors raised concerns with the peripatetic manager at 12.30 pm. Two of these people had not received a drink since 8 am. A member of care staff told us they did not have enough staff on the unit to provide people with the support they needed to eat and drink.

On the first day of our inspection we observed one person on the nursing unit calling out for assistance for 45 minutes. They were shouting from 10.30 am that they wanted to get up and we heard them say on several occasions, "I want my porridge." We saw this person was supported to have their morning personal care at 12.10 pm when a member of care staff said, "Poor man there will be no porridge left now." There was no evidence within their records to say this gentleman had been supported to eat since the night before.

We saw another person on the nursing unit being assisted with their morning personal care routine at 12:30 pm. We spoke with the agency nurse who said, "I am positive [Name] has not had anything to drink and I cannot establish whether they have had anything to eat. They have now been taken downstairs for some lunch." The agency nurse advised they did not have sufficient staff to ensure people received the care they required. This meant that people living on the nursing unit were not having their basic care needs met in respect of nutrition and hydration.

We asked the peripatetic manager to arrange an urgent GP review for two people to ensure they were not clinically dehydrated. The GP visited and advised neither person required hospital admission.

There were seven people on the nursing unit who had food and fluid records in place. We reviewed all of the charts and found people were not receiving an adequate fluid intake. NHS guidance indicates older people should have at least 1600 mls of fluid per day and states, 'Older people may have a weaker sense of thirst and, if necessary, should be helped and encouraged to drink regularly'. We found fluid chart entries were not 'totalled up' at the end of each shift. This meant no one had oversight as to whether people had received an adequate fluid intake based on their individual needs. As a consequence of this no action was taken to ensure people were adequately hydrated.

We reviewed the food and fluid charts for people receiving pureed diets. We were able to confirm that in the week before our inspection people who required a pureed diet were given the same meal at lunch and dinner time. A member of staff told us that this was done for ease of the chef so they did not have to puree two meals. This meant people were not offered or provided with choices about their meals and there was no evidence that people's individual preferences were taken into account.
In addition, we did not see that the food recorded as given had been pureed. For example, staff had recorded the meal for example, 'pork, mash, veg and gravy.' We checked with the kitchen staff who had a list of people who required pureed diets and identified this was a record keeping issue.

There was insufficient oversight of people's body weights. We saw evidence of one person on the nursing

unit having lost a significant amount of weight. The peripatetic manager had recorded this within their weight loss audit. The person had lost five kilograms of weight between July and September 2016. However, there was no record of any action being taken which meant the person was at risk of continued weight loss. We spoke with the peripatetic manager regarding this and were told that the person's weight loss was due to a medical condition and was not cause for concern. However, this was not recorded anywhere within their care plan and there was no risk management plan in respect of how the person's weight should be monitored.

The above findings demonstrated that people's nutritional and hydration needs were not being met which is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, this evidence also provided additional evidence of the very serious failures to ensure the provision of safe care and treatment which was a breach of Regulation 12 of the regulations and these matters will be considered and pursued under this regulation.

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 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 DoLS.

At the time of our inspection we asked the peripatetic manager how many people living at the service had an authorised DoLS in place. They told us that they were not aware of anyone living at the service with an authorised DoLS in place. However, we identified people across both the residential and nursing units who were subject to supervision and restrictions such as bed rails and sensor alarms to alert staff to people moving around. On the nursing unit two people had specialist chairs in their bedrooms which meant they would be unable to get out of the chair without assistance from staff. This meant people living at the service had their liberty restricted without the authorised safeguards in place.

During our inspection the peripatetic manager told us they were aware they needed to establish who had restrictive measures in place, who had a DoLS applied for and granted and then apply to the local authority as the authorising body to ensure these were requested. However, on the final day of our inspection the peripatetic manager and other managers supporting the service were still unable to confirm the number of people with sensor mats in place and who lacked the capacity to consent to these. In addition, we did not see evidence that people had consented to the care and treatment which was being provided to them. Although we saw staff seeking consent from people we found that care files did not consistently evidence that people had consented to the care and support provided.

This meant the registered provider had not ensured they were working in line with the principles of the Act and associated legislation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we saw evidence of staff supervision taking place this was mainly group supervision or individual

supervision in response to specific concerns. Supervision is an opportunity for staff to discuss any training and development needs any concerns they have about the people they support, and for their manager to give feedback on their practice. We found a lack of staff competency checks, which would have identified some of the concerns we found and supported staff to understand these and make the improvements, which were required. We concluded there was a lack of management oversight or effective leadership for staff within the service to model. This meant that staff had not received the support they required to deliver effective care.

Training certificates within staff files were from the previous registered provider's training. We reviewed the current training matrix which showed that only two members of staff were trained to administer medicines and only one member of staff had completed basic life support training. Only 63 per cent of the staff team had completed fire alarm and evacuation training.

This meant the registered provider had not ensured that staff had received appropriate support, training or supervision to enable them to effectively carry out their duties. This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave mixed feedback about the food on offer. One person said, "The food isn't bad, my pudding was nice." Another person said, "The food is not bad but it was a bit sloppy. It had no taste and the vegetables were mushy." During our inspection, we spoke with the peripatetic manager about the food and raised the concerns we had regarding people's choices, especially those people requiring a pureed diet. The peripatetic manager told us that there had been some issues with the quality of the food provided by the chef and these were being addressed. During the inspection, the chef resigned and left. A new chef, who was experienced in care provided cover and we were told they had a good understanding of how to meet people's nutritional needs along with ensuring people were offered a choice of meals. The chef had completed relevant food safety and hygiene training. However, there were no training records to say they had attended specific training in respect of nutrition and hydration needs for people who required specialised diets or were living with dementia.

The service had recently been redecorated in the entrance and dining room and people told us it felt lighter and brighter. The service was designed to meet people's physical care needs, corridors were spacious and there was a lift. However, for people living with dementia no adaptations had been made to ensure the environment supported them to be as independent as possible.

Requires Improvement

Is the service caring?

Our findings

Although we saw staff being kind and compassionate they were not provided with the direction and leadership required to ensure people received a consistently good standard of care. We saw a variation in the quality of support provided to people who required assistance from staff to eat their meals. We saw one member of staff concentrated solely on the person, engaged in a discussion with them and provided a good description of food they were eating. However, another member of staff got up and moved around the dining room while supporting some to eat, which meant the person's meal was interrupted. This was not a dignified experience for the person who needed support.

We saw tables were nicely set and people were supported from their wheelchairs onto dining room chairs. Food was served pre plated and we could not establish whether people had pre chosen their meal. We noted variation in staff interaction with people they supported. Some staff were friendly and chatted with people. For example, we saw one member of staff took juice around to people and offered them a choice of drinks. However, another member of staff placed someone's meal on the table without speaking to the person.

On the residential unit we observed some positive interaction between staff and people who lived at the service and we saw some real kindness and compassion from staff. It was clear that staff knew people well. They were able to engage in conversation about people's personal lives, their friends and relatives and could share a joke. There was a discussion about knitting poppies for a community initiative.

One person, living on the residential unit, told us that staff respected their privacy. They said, "Everyone always knocks on my door no one comes straight in. My wishes are always respected. Overall I am very happy at Sowerby House [nursing home]."

One relative we spoke with said, "We are very happy with the service so far." Their relative had only moved into the service in the summer and they described how difficult it had been for them to adjust and that their relative had struggled to settle in but they said, "The staff have been very supportive and responsive to his needs."

We observed good moving and handling practices on the residential unit. Staff took time to support people to move safely and explained what they were doing and reassured people.

We concluded the delivery of care, on the residential unit, was reliant on individual members of the staff team, who knew people and demonstrated a commitment to caring for people. It was not based on good leadership, systems and record keeping which would enable the registered provider to assure themselves they were delivering good quality care or to improve the service provided.

Requires Improvement

Is the service responsive?

Our findings

Care planning documentation was not adequate and did not always reflect the care which was being provided to people. We found care was not assessed, planned or delivered in a person centred way. Person centred care means ensuring the person is at the centre of everything which is done for or with them. This involves taking into account people's individual wishes and needs. Some of the care plans were difficult to follow and did not contain detailed information to enable care staff to know how the person should be supported.

Care plans did not always reflect the person's current needs and we could not see evidence of regular reviews or updates to care plans. Care plans should have been evaluated and updated monthly, or sooner, depending on people's changing needs. However, we saw a number of care plans across the nursing and residential unit which had not been evaluated since June 2016 and did not reflect people's current care needs. The regional manager accepted that this was the case and told us they had provided clear direction to the peripatetic managers who had been in post that these evaluations and care plan audits should have taken place.

There was a lack of leadership within the service which meant that people's changing needs were not consistently responded to. For example, we saw a GP had been asked to visit one person on the nursing unit on 14 October 2016. We spoke with the GP and they said they had been called out to review the person's legs which were swollen. However, the GP expressed concern that the person had been seen by their colleague on 11 October 2016 who had prescribed diuretic medicines which had not been started. Diuretic medicines can be prescribed to reduce swelling caused by fluid retention. In addition to this the GP had requested a blood test be taken, this had not been done and the GP arranged for the community nursing team to visit and take the person's blood. This meant the person had not been provided with the treatment they required and there was a lack of oversight on the nursing unit to ensure follow up of the issues raised.

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

The regional manager had previously identified that care planning documentation needed to be rewritten and transferred onto the current registered provider's paperwork. They had devised an action plan and delegated these tasks to senior members of the care team and management team. We were told staff were provided with supernumerary hours when they could focus specifically on this area of work. However, it was evident from our inspection that care records had not been updated and there was no effective management oversight to ensure this work was carried out.

A more recently developed care plan seen on the residential unit was detailed and provided staff with the guidance they required to ensure they could effectively meet the person's needs and provide a good standard of care in line with their individual preferences.

People on the residential unit told us they had access to a range of activities which they enjoyed. The service

employed an activities co-ordinator and people spoke affectionately about the support they received from them. One person said, "[Name of activities co-ordinator] is tops, she'll help you with anything you need."

People knew how to raise concerns or complaints. We reviewed the complaints log and could see one ongoing complaint which was being investigated by the peripatetic manager. Prior to this there had been three written complaints which were recorded within the complaints file. They were all related to concerns from relatives about the approach and attitude of individual staff members. These were investigated and responded to appropriately. However, we were concerned as one family member told us they had raised a concern with the manager and we could not find a record of this. We are following up this matter with the registered provider.

Inadequate

Is the service well-led?

Our findings

The current registered provider took over the running of the service in March 2016. At the time of our inspection the service did not have a registered manager. The previous manager had registered with the Care Quality Commission in January 2016 and left in July 2016. Since this time the service had been managed by three different peripatetic managers. At the time of our inspection the current peripatetic manager had been in post for four weeks. We are pursuing the absence of a registered manager separately with the provider.

During the first day of our inspection the regional manager informed us that the provider had made the decision to apply to de register the regulated activities associated with nursing care. They told us this was due to ongoing issues with recruitment and retention of nurses. This meant that the registered provider had decided they were no longer able to provide nursing care. The local authority and clinical commissioning officers were informed, by the regional manager acting on behalf of the registered provider of this in order for them to support people who needed to find alternative nursing home placements.

There was a lack of effective leadership and management oversight at the service. It was difficult to obtain key pieces of information we would expect the management team to know. For example, they were unable to tell us who had Deprivation of Liberty Safeguard authorisations in place.

The peripatetic manager told us, "I am confident that we are delivering safe care to people." However, we found governance arrangements were poor and identified multiple serious failings particularly in respect of care delivery, risk management and care planning. There were no effective systems in place to ensure people received safe care.

We asked to see records of quality assurance audits and were told these had commenced in September 2016. We saw evidence of a monthly bed safety rail audit which had checked the safety of the bed rails. However, the peripatetic manager had failed to identify that people who had bed rails in place did not have a risk assessment in respect of these. Also, they had not checked that people had agreed to these. In addition, we saw a monthly weight loss audit had taken place on 28 September 2016 where it had been identified one person had lost 3.7 kg in weight between July and September. There was no record of any action taken to address this weight loss or why no action had been required.

We were told that audits of care plans had been delegated to the acting deputy manager, (who was not at work during our inspection) and a senior member of care staff. The peripatetic manager told us that staff had been given supernumerary hours to complete these however they had not checked whether these had been completed.

The management team had failed to identify that regular fire safety checks had not been taking place across the service which meant people were at risk of harm. The last fire alarm test had taken place on 30 August 2016. Weekly fire alarm tests had not been completed or recorded. We were told by the peripatetic manager this was because the maintenance person was off work. Other essential safety checks had not been

completed on a regular basis. For example, fire escape routes should have been checked weekly but these were last checked on 30 August 2016 and the emergency lighting should have been checked monthly but this was last checked on 9 August 2016. This meant that the service could not be assured that there were safe systems in place to ensure people's safety in the event of an emergency situation. We have shared these concerns with the local fire safety office at North Yorkshire Fire and Rescue Service.

The peripatetic manager told us that a lot of their time had been spent dealing with staffing issues including recruitment, sickness monitoring and disciplinary matters. They said, "There has been a culture of staff not being effectively managed and being allowed to do what they wanted." We were told addressing this had taken a considerable amount of their time.

Record keeping was inadequate, for example we found staff had recorded the type of food someone had eaten such as, 'pork, mash and vegetables' but there was no record to indicate if this was pureed food. We established this was a recording issue but it meant we could not be confident people had been supported to eat safely.

The registered provider had not given consideration to the risks posed to people from them not having their needs assessed appropriately and the persistent poor care practices left people at risk of significant harm to their health, life and wellbeing.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

The registered provider had arranged for an 'impact visit' which was conducted by a quality manager on 10 and 11 October 2016. They identified a number of the same issues that we found during our inspection. For example, care plans had not been updated and the quality of some care plans needed to be improved, risk assessments needed to be put in place, accident analysis was not taking place and audits were not all completed or actioned. In addition, the regional manager had developed detailed action plans and had delegated the responsibility to the peripatetic managers to address. However, it was evident these actions had not been addressed.

The registered provider had failed to notify the Commission of serious incidents which they are required to do by law. For example, we were not notified about two individual safeguarding matters or a serious injury which one person had sustained whilst living at the service. This was a breach of Regulation 18 (Notifications of other incidents) of The Care Quality Commission (Registration) Regulations 2009. We are pursuing the failure to notify separately with the provider.

During the inspection we contacted the registered provider to express our concerns about the lack of clinical oversight at the service.

Following our inspection the regional manager arranged for another peripatetic manager to take over the running of the service and the regional manager was offering daily oversight to support the safe transfer of people to alternative nursing home placements and to start work on improvements that were required within the residential unit.

The regional manager informed us that they had recruited a new manager who would apply to become the registered manager at the service once all of the required recruitment checks had taken place. During the inspection the regional manager provided the Commission with an urgent action plan to address the concerns we had identified during our visit.