Dr & Mrs M K Vachhani

Le Grand Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 7 and 8 April 2015 and was unannounced.

The last inspection of Le Grand Nursing Home took place across five dates in September/October 2014. At that time we found concerns in care planning, arrangements to safeguard people against the risk of abuse, procedures for obtaining valid consent were not in place, people were deemed to be unlawfully restrained and their liberty compromised. Systems and processes to monitor and check the quality of the service provided were poor and inadequate. We deemed these concerns to have a major impact on people.

As a result of our findings we commenced enforcement action against the provider who was issued with five warning notices for failing to meet the requirements of regulations 9, 11, 10, 18 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time.

During this inspection we reviewed actions taken by the provider to gain compliance against five warning notices issued to the service following the previous inspection in

Summary of findings

September/October 2014. We also looked to see if improvements had been made in respect of the additional shortfalls in people's care we had identified. We found that no improvements had been made.

Le Grand Nursing Home as a condition of its registration should have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home had not had a registered manager in place since November 2013.

The manager had not registered with the Care Quality Commission. An application was submitted, however due to recording errors this was declined and returned for amendment.

Le Grand Nursing Home provides nursing and residential care and is registered to accommodate up to 28 people. There were 14 people living at the home when we visited.

We engaged with all people living at the home, feedback varied due to some people having limited communication skills. We spent time observing care delivery and spoke with people who visited the service.

People told us that they felt safe, however comments about a lack of staffing consistency infringed on the day to day experiences of care received.

We found that people were not protected against avoidable harm and quality assurance systems at the home failed to identify or resolve associated risk, therefore placing people at significant risk of harm and neglect. We communicated our concerns to associated commissioning teams and ensured that the standard of risk management at the service was addressed by the provider before leaving the site on both days of inspection.

We found that people's safety was being compromised in a number of areas. This included how people were assisted to eat and drink, use of equipment during moving procedures, how well medicines were administrated and suitability of pre-employment checks for staff prior to recruitment.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. For example, the provider had not ensured that people's rights were actively assessed under the Mental Capacity Act of Deprivation of Liberty Safeguards, even though their liberty was being significantly restricted.

We found that people's health care needs were not appropriately assessed therefore individual risk factors had not been fully considered, placing people at risk of avoidable harm.

Although some people told us they felt safe and their privacy and dignity was respected, we saw that care was predominantly based around tasks and did not take into account people's preferences. We were concerned that some very frail people living at the home were isolated in bedrooms with little stimulation.

The home did not consistently involve people in decisions made around the care they received. Care plans did not evidence involvement and observation of care confirmed concerns regarding standards of dignity and respect.

We received variable feedback from relatives; some expressed positive comments about the care provided whilst others were concerned about the high use of agency workers and inconsistency in effective communication between staff at the home.

We did not find evidence of robust management systems in the home and quality assurance was not effective in order to protect people living at the service from risk.

Staff were not provided with effective support, induction, supervision, appraisal or training. The home did not have any effective governance systems in place to ensure that improvements can be made.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have deemed that the overall rating for this service is inadequate.

We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore we have introduced special measures.

The purpose of special measures is to:

Summary of findings

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

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

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

Services rated as inadequate overall will be placed straight into special measures.

You can see what action we have taken at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not appropriate and effective systems in place to identify the possibility of risk and to prevent harm to people living at the service.

The processes in place to ensure that people received their medicines as prescribed were not robust and placed people at risk of harm.

People were not safeguarded against risk of neglect and avoidable harm.

Recruitment systems were not robust to ensure the safety of people living at the service.

Staffing levels at the home did not support effective provision of care standards.

Is the service effective?

Inadequate

The service was not effective.

People were not supported in line with the Mental Capacity Act 2005 to ensure that their ability to consent was appropriately assessed prior to decisions being made on their behalf. Some people were unlawfully restricted.

The systems in place to ensure that people received nutrition and hydration appropriate to their needs were not robust therefore placing people at risk of choking and malnutrition.

Staff training and supervision were not effective to ensure that staff were competent and had sufficient skills to meet the needs of people they cared for.

Is the service caring?

Inadequate

The service was not caring.

There were not appropriate and effective processes in place to make sure people were involved in discussions regarding their preferred care and treatment.

The systems and procedures operated at the home were not designed to enable people to live their lives in the way they choose, so that they can be as independent as possible.

People were not always treated with dignity and respect and the standard of personal care people received was found to be unsatisfactory.

Is the service responsive?

Inadequate

The service was not responsive.

There were not appropriate and effective processes in place to make sure people's health and social care needs were properly assessed and planned.

We found peoples care needs were not appropriately planned for by the service. The service failed to respond to peoples changing needs by ensuring amended plans of care were put in place and liaison with other health care professionals at times of deterioration in health status.

Summary of findings

People's wellbeing and stimulation was observed to be minimal, a lot of people spend time in their bedrooms without stimulation and observation of care demonstrated a task focused culture.

Is the service well-led?

Inadequate

The service was not well led.

There were not appropriate and effective processes in place to make sure that the quality of service was assessed and monitored to ensure people received safe and appropriate care.

The service was unable to demonstrate progression since the last inspection and had not met breaches outlined in the issued warning notices.

We found that due to insufficient awareness of people's needs by the management structure people were at risk of avoidable harm.

Le Grand Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 8 April 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors, two specialist advisors, one for medications managements and another for nursing care, along with one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information from our own systems which included notifications from the provider, safeguarding alerts and a number of whistle blowing concerns. In particular, information we had received since our last inspection in September/October 2014.

We reviewed the content of the five warning notices issued to the provider following the previous inspection in September/October 2014 where a number of breaches were identified under the Health and Social Care Act 2008 (regulated Activities) Regulations 2010 which were in force at that time. We also looked at actions we had asked the provider to take in order gain compliance with additional breaches of the regulations which had not been covered by those warning notices.

We gained feedback from external health and social care professionals who visited the home. As part of this we were provided with auditing information undertaken by the local Clinical Commissioning Group (CCG) and have received regular updates from the associated professionals at the local authority.

We spent time talking with people who lived at the home and where possible their relatives, reviewed records and management systems and also undertook observations of care delivery.

We spoke with all people who use the service, the provider, manager, clinical lead, three registered Nurses, seven care staff, cook, activity co-ordinator and the visiting hairdresser. We looked at ten peoples care records, staff duty rosters, four recruitment files, management audits, medication records and quality assurance documents.

Inadequate

Is the service safe?

Our findings

During our last inspection of Le Grand Nursing Home we found short falls regarding procedures for keeping people safe. We found that people at risk of falling had not been adequately assessed and monitored therefore placing them at increased risk of injury and the provider failed to have suitable arrangements in place to identify the possibility of abuse . We deemed this to have had a major impact on people. As a result of our findings we started enforcement action against the provider who was issued with a warning notice for failing to meet the requirements of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time. The provider was given until 12 February 2014 to become compliant with this regulation.

During this inspection we reviewed requirements outlined in the warning notice issued following inspection of the service in September/October 2014. We reviewed compliance against the new associated regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found continuing concerns that the provider had not met the required standard and was in breach of this regulation.

Feedback from people living at the home was minimal due to limited communication abilities and advanced care needs. However people who lived at the service told us “Yes I feel safe, I am ok here” and “I have a buzzer in my bedroom but if I use it at night no one comes and they don’t check on you very often, they don’t listen to you”.

We spoke with visiting relatives and variable feedback was received “Any concerns I can speak to the staff anytime, I am kept in the loop if they have concerns too”. “Agency staff are not very helpful or as active as staff here”.

We found during this inspection, from records we looked at that staff had received training in the safeguarding of vulnerable adults. Staff members we spoke with were able to explain the main principles of protecting people from abuse, however when we looked at how this was put into practice, we saw that three safeguarding concerns had not been recognised by the staff or reported to the manager or other senior staff. Two people had been without prescribed medicines for a significant period of time potentially causing them to have adverse effects such as mood disturbance and weight loss, staff were aware of this however failed to escalate this information to senior staff or the home manager.

We also found that the manager had not picked up on these incidents and was not aware of them. During our inspection we had to draw her attention to these incidents and prompt the manager to act in an appropriate manner and report the incidents to the local authority as safeguarding alerts. As an example when we raised concern about a person who had not eaten for the previous five days the managers response was “That is shocking”. A system of effective communication was not active at the service to ensure that peoples deteriorating health needs and associated risk was actively managed. This meant that systems and processes were not in place to prevent incidents of abuse to people who used the service.

This amounted to a breach of regulation 13 (2) and (4) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not protected against avoidable harm or risk. Due to inappropriate systems at the home to assess and monitor people’s health and social care needs we found that risks associated with every day care provision were compromised. Appropriate risk assessments were not in place for people who lived at the home which placed people at risk of receiving care that was not appropriate for their needs and preferences to keep them safe.

As an example we saw that one person had returned to the home after a transitional period in hospital. On return to the service risk assessment and care planning was not undertaken to ensure that the person’s needs were met. This persons needs had changed during their stay in hospital and they now required a higher level of care and support, changes in the person’s ability to mobilise, eat and drink independently and communicate were evident. The provider had failed to assess the persons needs and provide the level of support now required, action was not taken to seek advice from the persons General Practitioner despite this person having limited nutritional and hydration intake for a significant period of time.

We found that another person living at the home was being provided food types that put them at risk of choking, the person required a diet consistency of puree type due to

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Is the service safe?

swallowing difficulties and it was evidenced that the home had failed to protect this person from avoidable harm due to providing foods that potentially could have caused them to choke. The provider had failed to take necessary precautions to ensure the safety of this person was communicated throughout the staff team and reflected in care records.

This lack of risk assessment and care planning amounted to a breach of regulation 12 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed requirements outlined at the previous inspection in relation to non-compliance with medicine management, Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; we inspected against the new regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found continuing concerns that the provider had not met the required standard was in breach of this regulation.

We found that medicine management systems were not robust, placing people at risk of not receiving their medicines as prescribed.

For example we found that the provider failed to identify omissions in medicine administration and a lack of information to support administration of 'as and when required' treatments were evident. One person had been given a double dose of their medicine for a prolonged period of time; this had not been identified by staff or the manager despite a recent medicine audit being completed in April 2014. Another person had been administered a topical prescribed treatment for a total of 23 days, the actual prescription direction was for this treatment to be administered for 10-14 days this highlighted that people were at risk of not receiving their medicines as prescribed, we requested that the manager made safeguarding referrals for two people at the home in regards to medicine management, the manager was unable to explain why internal auditing systems completed in April 2014 had not found these concerns.

We checked medicine records for fourteen people living at the home, omissions in the recording of administration were identified and hand written medication record details were not adequately recorded to ensure that safe administration was achieved.

We found that recording of the topical treatments was inconsistent, treatments were being applied by care workers at the registered nurse's request, however records to evidence this application were not available to ensure that correct application was achieved. The person administrating these treatments should have clear direction and demonstrate accountability by signing administration records. Safe storage and cleanliness of topical treatments was found to be insufficient.

Systems to manage stock of medicines at the home were compromised due to ineffective procedures of recording when medicines were received; this meant that auditing processes could not be achieved, potentially infringing on investigatory processes when errors in medicine management are identified.

We found at this inspection, by reviewing the training records, that some staff had received medicine training. However we were informed by the manager that the majority or errors in medicine management are due to high agency nurse use and a lack of staffing consistency. We were concerned about the insufficient level of monitoring at the home around medicines to ensure that people received their medicines in a safe way.

This amounted to a breach of breach of regulation 12 (2) (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed requirements outlined at the previous inspection in relation to non-compliance with Cleanliness and infection control, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; we inspected against the new regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found continuing concerns that the provider had not met the required standard was in breach of this regulation.

We received professional feedback that raised concern about how the provider responded to and managed a recent outbreak of infectious disease. We were informed that delayed referral processes were thought to have increased the level of risk at the service and concern regarding the standard of staff knowledge of safe practices and referral processes highlighted concern.

We observed poor practice within the home; staff failed to remove protective clothing at point of care and were seen to walk around the service in aprons and gloves that had

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Is the service safe?

been used during personal care interventions. We communicated to the manager that this increased the risk of cross contamination, however malpractice continued to be observed.

During this inspection we found that training records indicated that staff had undertaken infection control training; however the quality of this training and accuracy of training records was questioned. The training matrix indicated that all staff completed training courses on the same dates. Staff told us that their recent training had been by watching DVDs and this was usually undertaken during their duties. No evidence of competency based assessments were available to reflect the level of staff understanding or to highlight further training needs.

This amounted to a breach of breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to look at the recruitment records for three people who worked at the home. The manager advised us that she had started to audit staff personnel files and had already identified that some staff did not have references. We looked at three recruitment files and found that the provider had not made sure that suitable referencing was obtained prior to agreement of employment. Robust recruitment processes help to ensure that the applicant is suitable to work with people who may be vulnerable.

These shortfalls amounted to a breach of breach of regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

During our last inspection of Le Grand Nursing Home we found short falls regarding procedures for ensuring people living at the service received effective care. We found that procedures to ensure that the service was sufficiently staffed were not in place to ensure that effective care and support was provided; we observed that people were not responded to within a timely manner and a high use of agency workers including insufficient numbers of employed staff caused deficits in the continuity of effective care for people living at the service. We deemed this to have had a major impact on people. As a result of our findings we started enforcement action against the provider who was issued with a warning notice for failing to meet the requirements of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time. The provider was given until 12 February 2014 to become compliant with this regulation.

During this inspection we reviewed requirements outlined in the warning notice issued following inspection of the service in September/October 2014. We reviewed compliance against the new associated regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found continuing concerns that the provider had not met the required standard and was in breach of this regulation.

We found that the provider had not taken appropriate steps to ensure that there was sufficient numbers of suitably qualified, skilled and experienced persons employed in order to safeguard the health, safety and welfare of service users. For example we observed that people's individual needs were not fully considered in the afternoon and early evening. We observed poor standards of dignity during dining due to insufficient staff presence in the dining room to support people who are unable to eat independently. One staff member was observed to assist three people at once to eat their dinner. Person centred care delivery was not achieved and people did not receive a good experience at meal times. Due to a lack of individual support we noticed that people did not eat much of their meal. We observed that the quality of care depreciated in the afternoon time when care workers were expected to undertake ancillary duties: this was reported at the previous inspection and the provider had not taken sufficient steps to ensure that this issue was addressed.

Care workers, nurses and relatives told us that a high use of agency workers meant that good care and communication was constantly compromised, and this had a negative impact on people's wellbeing and safety.

A visiting relative informed us "Agency staff are not very helpful or as active as staff here".

A care worker told us "Communication at the home is poor, we do not receive very good hand overs from the nurses and we are not told of any changes if we have been off duty for a few days".

We found this information to be very concerning and when we discussed this with the manager it was confirmed that communication standards were an area requiring immediate improvement. The manager explained that she did receive effective communication from staff on a daily basis, and was unable to confirm what systems had been put in place to improve communication at the service. We found it concerning that the manager was not aware that one of the people living at the home had not eaten for five days. We took action to ensure the person was safe guarded by making a referral to the local authority safeguarding team. We asked the manager to take immediate action to protect this person from the risk of further neglect and was reassured that they received medical assessment by their General Practitioner on the same day that we raised the concern.

We reviewed a selection of training records and found that staff training had been considered by the provider. However, the training records did not identify how the provider had assessed staff understanding, knowledge and competency skills.

Staff told us that they had received training via a DVD or on-line however they were unable to provide a satisfactory level of feedback to us when we asked them about subject areas such as the Mental Capacity Act 2005, nutrition, hydration and tissue viability.

This amounted to a breach of breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

During our last inspection we found short falls in the systems to ensure that the service involved people in decision making and the ways people were supported when considering consent to treatment or restrictive practices. We deemed this to have had a major impact on people. As a result of our findings we started enforcement action against the provider who was issued with a warning notice for failing to meet the requirements of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time. The provider was given until 12 February 2014 to become compliant with this regulation.

During this inspection we reviewed compliance against the new associated regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found continuing concerns that the provider had not met the required standard and was in breach of this regulation.

We found that suitable arrangements were not in place for obtaining consent from people living at the home, and as a result care practices were not provided in accordance with people's wishes or best interests.

We found that one person living at the service had a care plan detailing their end of life care priorities. This had been completed by their relative however there was no evidence to show that the person themselves had been involved in the process or informed about these decisions. The Mental Capacity Act 2005 stipulates that a person must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision making process.

During the inspection we reviewed care planning records and found that they did not indicate how people were supported and involved in the care planning and review process. For example one person's care records detailed how the service had implemented a sensor alarm mat to alert staff as to when the person moved. Care records indicated that this was in place to reduce the risk of falls for the person however information regarding how the person was involved in the decision making process was not included. Considerations around their continuous control and restraint, in line with the Mental Capacity Act 2005, were not recorded

This amounted to a breach of breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we found some people at the home were subjected to restrictions which amounted to a deprivation of their liberty and had asked the provider to take immediate action. As a result of our findings we started enforcement action against the provider who was issued with a warning notice for failing to meet the requirements of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time. The provider was given until 12 February 2014 to become compliant with this regulation.

During this inspection we looked at restrictive practices within the home and reviewed compliance against the new associated regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found continuing concerns that the provider had not met the required standard and was in breach of this regulation.

We found evidence that a number of DoLS (Deprivations of Liberty Safeguards) had been applied for and the manager confirmed that these restrictions were active. However the service provider failed to ensure that appropriate recording of restrictive practices were achieved including making sure that urgent authorisations to deprive a person's liberty were reviewed in a timely manner and considered by the managing authority for being authorised for an agreed period of time. For example people were being prevented from leaving the service as the home had a locked door that needed to be opened with the use of a key. People could only have access to the key if they asked a staff member. The records indicated that this was done in their best interests to ensure safety, however the provider failed to follow essential steps to ensure that restrictive practices

were undertaken in a lawful way. We could not find written evidence to show that people and or their representatives had been involved in considerations for this deprivation of their liberty.

This amounted to a breach of breach of regulation 13 (4) (b) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the inspection we reviewed the way the home met people's nutritional and hydration needs: We reviewed compliance against regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found concerns that the provider had not met the required standard and was in breach of this regulation.

We found that people were at significant risk of malnutrition and dehydration. People were not appropriately assessed and when people had lost a substantial amount of weight a referral to external professionals such as their GP and, or Dietician was not undertaken. For example we looked at nutrition care records for one person living at the service and found that the person was able to tolerate a "soft diet" preferring "finger foods". Care workers told us that the person required "a blended diet" and this was corroborated by the cook. We highlighted the risk of choking to the service manager on the first day of inspection who confirmed that actions would be taken to ensure that care records were amended to reflect the persons needs and that all staff would receive a formal handover of the issues. On the morning of the second day of inspection we examined nutritional intake records for the same person and found that a night care worker had provided solid foods early in the morning that placed the person at considerable risk of choking.

We looked at several care records relating to nutritional risk management and individual preferences and found evidence of inadequate risk assessment and involvement procedures in all the records we viewed. This meant that people had not been appropriately supported to maintain their individual nutritional and hydration needs. For example people had not been weighed in accordance with direction recorded in their care plan and when people had lost weight actions had not been taken to protect the individual from further weight loss or malnutrition.

We found that there was no policy available at the home to outline expected nutritional standards. Care workers and registered nurses informed us of their knowledge around nutrition management and definition of texturised diets and it was evident that a lack of understanding was embedded throughout the workforce. We were unable to find evidence of staff training or support around meeting people's nutritional and hydration needs.

This amounted to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure people's individual nutritional needs were met.

We spoke with people at the service who communicated positive comments about the quality of the food "the food has really improved" and "lovely food".

We observed meal times across both days of inspection and found that the evening meal service was rushed; people were not assisted to maintain their dignity and independence due to an insufficient amount of staff to provide support. For example we observed care interventions during meal service when a visiting General Practitioner came to the home. The person was examined in the lounge area and their meal was taken away without communication or consideration for the person's preferences. We felt that dignity and respect standards were not observed or considered. This resulted in the person later refusing to eat their meal and this caused a significant level of distress to the individual.

We observed that people were not offered choice during the evening meal service. Staff appeared rushed and task focused. People in the dining area were not offered the use of clothing protectors and during the meal one person was observed to feel embarrassed when they spilt food on their trousers Staff did not respond to this person's needs or consider the persons wellbeing.

This amounted to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure people's respect and dignity was preserved.

Inadequate

Is the service caring?

Our findings

People told us contradictory things about the service they received. While some people were very happy, others were not. Also, our own observations did not always match the positive descriptions people had given us.

Two people who lived at the service told us "The regular workers are kind" and "I do feel safe here".

Another person at the home said, "Agency staff are not very helpful or as active as staff here" and "I have a buzzer in my bedroom but if I use it no one comes at night they don't check on you very often, they don't listen to you".

Two relatives told us "We can come and visit anytime and the staff are happy to see us". Another said "(My relative) has been here five years and we are quite happy because they are happy".

We saw that support for people living in the service was variable. Care workers were observed to be kind and considerate during some interventions, however delayed response times to people's requests were observed on a number of occasions. For example we observed one person sat at the end of their bed. The person required support to get back in bed and confirmed that this was their request but they could not summon staff help. We informed the nurse in charge who did not respond. We therefore used the emergency sensor alarm to alert staff. The person had to wait an unreasonable amount of time for assistance however once staff responded the person was supported safely back into bed.

We observed that a high number of people stayed in their beds both day and night, and that people who had been able to sit in the communal areas were then assisted back to bed in the early afternoon. This left three people able to access the dining area for the evening meal.

We noted some interactions to be task focused and care workers failed to actively communicate with people when assisting them on some occasions. For example we observed a care worker sit with a service user for a short period of time, the interaction showed a substantial level of warmth and the person was genuinely comforted by the staff's presence. However another person was observed to request support from staff three times during meal service as they wanted a drink, and this request was ignored until we asked staff to respond.

We visited people in their own rooms with agreement, and noticed that the standard of personal care for people approaching the end of their life was not to a high standard. Three people were observed to have sticky eyes, dry mouths and did not appear comfortable. We asked the manager to ensure that these people's needs were addressed and this was then achieved. We were told by the manager that mouth hygiene kits are not routinely provided as a matter of course for people approaching the end of their lives. Despite us asking, no one was able to give us any reason as to why this had not been considered or provided.

During the inspection we reviewed care records for a person who had recently returned from hospital with end of life care needs and found that end of life care planning had not been fully considered. This was despite the person not eating and drinking for the previous five days. The person had returned from hospital with complex health care needs and it was evident that the provider had not adequately assessed the person's needs in line with best practice principles as outlined in the provider's end of life care policy. This impacted on the quality of end of life care for this person.

We found that partnership working with people at the home, and other agencies was not planned or effectively put into action. People living at the service and their relatives told us that they would like to be involved in discussions about service provision however are not given the opportunity to do so.

This amounted to a breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure people were cared for in a person centred way with consideration of consent to care and treatment.

Inadequate

Is the service responsive?

Our findings

During our last inspection of Le Grand Nursing Home we found short falls regarding procedures for ensuring people living at the home received appropriate care and treatment that suited their individual needs. We found that the care we observed was not as outlined in the person's care plan and that care records had not been updated to reflect the person's current needs and preferences. We deemed this to have had a major impact on people. As a result of our findings we started enforcement action against the provider who was issued with a warning notice for failing to meet the requirements of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time. The provider was given until 12 February 2014 to become compliant with this regulation.

During this inspection we reviewed requirements outlined in the warning notice issued following inspection of the service in September/October 2014. We reviewed compliance against the new associated regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found continuing concerns that the provider had not met the required standard and was in breach of this regulation.

We found that the provider had not taken efficient steps to ensure that people living at the home received appropriate assessment of their needs and preferences. Information held with the care records of ten people showed that the care provided was not accurately recorded to show that it was in line with people's wishes and best interests, putting people at risk of receiving care that was inappropriate or unsafe. For example one person's care plan stated that they were able to mobilise with the aid of a stand aid, however care workers informed us that this person now required an electric hoist for all transfers and was predominantly nursed in bed. Evidence of safety assessments were not available and we discussed this with the manager who agreed that this significantly increased the risk of injury during care giving.

We found that the service was not responsive to known risk factors. Staff showed a lack of understanding around tissue viability and nutrition, and staff were not equipped to response to people's changing needs which placed people at substantial risk of deterioration in their health and wellbeing. For example one person's care records indicated that they were at very high risk of pressure area skin damage due to spending long periods of time in bed. The staff had provided a pressure relieving mattress however had failed to adequately assess the person's weight and calibrate the mattress settings to ensure that the equipment was effective. We found that care workers and nurses at the home were not aware that such equipment required setting in this way.

We reviewed the moving and handling care plans for several people and found that the records did not identify the correct moving and handling equipment used to assist people to safely mobilise. Staff were unable to identify individual needs with regards to sizes of electrical hoist slings and the slide sheets used to assist people to move around the bed. We discussed this with the home manager, and found that she did not have a clear understanding of best practice in the area of effective assessment and care planning in moving and handling. We found that the home did not have a responsible member of staff for coordinating clinical oversight despite a high use of agency nurses and the majority of people living at the home with significant health needs.

We found that wound management at the home was planned and recorded to a basic standard. However care records required more personalised detail to ensure that all areas of wound management were considered, including assessment of the person's pain, comfort experience and preferences.

We noted that the service manager did not demonstrate a clear understanding of person centred care. She told us that she was not competent in assessing people's complex and significant healthcare needs due to not being a registered nurse. This was concerning when also taking in account the fact that agency nursing staff were not reliable when undertaking risk assessments and active care planning in partnership with people living in the service.

We found that information held within peoples personal care records showed limited liaison with external health professionals regards peoples care and support. The manager explained that links with community teams such as the dietician and tissue viability services were poor; we found evidence to show that referral to these services were ineffectual.

We observed that people were not provided with stimulating person centred activities to promote their

Inadequate

Is the service responsive?

wellbeing or to prevent social isolation. For example we saw that most people were isolated in their rooms without means of entertainment, we did not find records to demonstrate that the service considers peoples social stimulation on a frequent basis. We found that the service does not have an activity programme to enable people at the service choice to engage with their preferred activities.

This amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure people were cared for in a person centred way.

We reviewed how the service responds to complaints and found that the manager did not keep robust records or show how complaints are responded to in a timely manner. We found information in a person's care file that showed a complaint raised by their relative regarding how they had not been informed about the persons change in health needs, the manager had not responded to the complaint in line with the complaint policy and procedure,

People told us that they were aware of the complaints procedure and one relative explained "I can tell the manager at any time if I have a concern", however robust records to show how the service responds to people's concerns were not available.

This amounted to a breach of Regulation 16 (1) (2) (3) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure that effective systems were in place for identifying, receiving, recording, handling and responding to complaints.

Inadequate

Is the service well-led?

Our findings

During our last inspection of Le Grand Nursing Home we found short falls regarding systems in place at the service to assess and monitor service provision. We found that the provider had failed to implement robust auditing systems to monitor safety and quality at the service. We deemed this to have had a major impact on people. As a result of our findings we started enforcement action against the provider who was issued with a warning notice for failing to meet the requirements of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which were in force at that time. The provider was given until 12 February 2014 to become compliant with this regulation.

During this inspection we reviewed requirements outlined in the warning notice issued following inspection of the service in September/October 2014. We reviewed compliance against the new associated regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and found continuing concerns that the provider had not met the required standard and was in breach of this regulation.

We found that the service continued to have inadequate systems in place to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included dignity and respect, nutrition, person centred care, medicine management, infection control, managing risk to people and staffing levels. These issues had not been sufficiently identified or managed by the service manager or provider prior to our visit which showed that there was a lack of robust quality assurance systems in place.

We did not find any written documentation to show that the manager or service provider had

properly established any robust monitoring systems. There were no effective audit systems in place for issues such as medicines, health and safety, risk assessments, care planning or the quality of food. For example the medicine audit completed March and April 2015 did not highlight systemic issues found during our inspection which posed a substantial risk to people who use the service.

We found that the service manager was unable to demonstrate suitable knowledge around risk management for people living in the service, with particular reference to people with significant and complex health care needs. The manager and service provider were unable to clearly demonstrate any significant progression in service delivery since the last inspection (September/October 2014) and was unable to clearly demonstrate that breaches in the regulations, as outlined in the warning notices, had been met.

The manager and service provider did not have a formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. There was no evidence of recent quality monitoring of care documents at the home. We found that care plans lacked detail and others did not contain appropriate advice for staff to follow. Other care plans were missing information about people's preferences, life histories and mental capacity assessments.

Since our last inspection in September /October 2014 we received numerous whistleblowing concerns from staff at the home. Whilst staff were happy to inform us of their concerns it was clear that reporting systems in the home were not robust and whistleblowing concerns highlight a lack of confidence in management response. However, a relative told us that they felt confident in reporting concerns and that they had positive responses when they had disclosed their concerns in the past.

We found that the provider had issued customer satisfaction surveys and ten surveys viewed were not dated however the overall comments were positive. One comment stated "Care staff need to be able to care for people rather than being involved in catering". However as they were not dated we were unable to ascertain when this survey had been completed and any of the comments made had been acted upon.

We observed a poor atmosphere in the home, with most of the communal areas populated by people and staff who seldom interacted with each other. We did not observe many examples of staff trying to engage with people who used the service or lift the atmosphere. There was no evidence of good leadership by senior staff to improve the experiences for the people who lived there.

None of the care and support systems in the home were based on current best practice. The home was disorganised and we found that there were no clear lines of responsibility. If tasks or care work did not take place then there were no systems in place to monitor this or for the

Inadequate

Is the service well-led?

manager to take appropriate action to tackle the issue. Staff informed us that they are not provided with clear direction and often come onto duty without a handover from the person in charge; this meant staff were not regularly updated with information to ensure that they provided safe and effective care and support for people living at the service.

This amounted to a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure people were cared for in a person centred way.

We found that the service did not have a registered manager in place. An application had been made by the current manager however due to errors in its completion this has been rejected and no further submission of application had been logged. The home had been without a registered manager for 17 months, the manager had been in post since November 2014 and we felt that consideration for registration had taken an unreasonable length of time to be acted upon.

This amounted to a breach of Section 33 of the Health and Social Care Act 2008.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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	Section 33 HSCA Failure to comply with a condition **The provider did not have suitable arrangements in place to ensure that the service was managed by a person registered with the Care Quality Commission, as required within the terms of providers registration.**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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 **The provider did not have effective arrangements in place to ensure that the care and treatment of service users was appropriate, outlined to meet their needs and reflected their preferences.** **Regulation 9 (1) (3) (a) (b) (c) (d) (e) (f) (g) (h) (i).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not have suitable arrangements in place to ensure that people are treated with dignity and respect. Regulation 10 (1) (2) (a) (b)**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3) (4).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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 **The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users. Regulation 12 (1) (2) (a) (b) (c) (e) (g) (h).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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 **The provider did not have suitable arrangements in place to protect service users from abuse and improper treatment. Regulation 13 (1) (2) (3) (4) (b) (5) (6) (d) (7) (b).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider did not have suitable arrangements in place to ensure that nutritional and hydration needs of services were met. Regulation 14 (1) (2) (a) (i) (b) (4) (a) (b) (c) (d) (5).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not have suitable arrangements in place to ensure that any complaint received is investigated and that necessary and proportionate action is taken in response to any failure identified. Regulation 16 (1) (2).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have suitable systems in place to establish effective assessment, monitoring and improvement of the service. Regulation 17 (1) (2) (a) (b) (c) (e) (f).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have sufficient numbers of suitably qualifies, competent, skilled and experienced persons deployed in order to meet the needs of people at the service. Regulation 18 (1) (2) (a) (b).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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 **The provider did not ensure that robust recruitment processes were in place to ensure that vulnerable people are protected from abuse. Regulation 19 (1) (a) (b) (2) (a) (b).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.