Fordent Properties Limited

Orchard Manor Care Home

Inspection report

Greenacres Court
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21 November 2016
23 November 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8, 21 and 23 November 2016.

Before our inspection we received concerns in relation to low staffing levels and the right mix of staff being available particularly during the night. We were also informed that people had been locked in their bedrooms overnight; staff had been told to undertake tasks which they did not feel confident to do such as administer medication to a person or assist with nursing procedures for which training had not been received; lack of training specifically in fire awareness and evacuation procedures. Other concerns included restrictions on the use of incontinence products. Members of the public had also raised concerns about the poor care people were receiving and anxieties regarding people's safety. This information was shared with the local authority safeguarding team who responded to our concerns and undertook an early morning visit to the service.

Following the concerns raised we carried out an unannounced comprehensive inspection which included a night visit. The first two days were unannounced, 8 and 21 November 2016 followed by an announced visit on 23 November 2016.

The last inspection was undertaken in April 2016 and the service was rated as requires improvement. Breaches of regulations were made with regard to management of medication; cleanliness of equipment, care plans not up to date and ineffective audit systems. An action plan was received from the registered provider and they stated they would be compliant by 31 October 2016.

Orchard Manor is a care home for older people, set in large grounds off Acres Lane. There are 93 bedrooms in total divided into two units: Maple unit has 48 rooms over three floors. Two floors provide care and support for people living with general nursing requirements and dementia care needs and one floor offered residential care. Willow unit has 45 bedrooms over two floors both of which provide care and support for people with nursing requirements and dementia care needs.

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

During our visits we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that the registered provider used a lot of agency staff and that staff were always very busy and rushed off their feet. Some people said the staff were okay and others said staff were very nice.

Although there were enough staff working within the home, we found that the deployment of some of the staff and their level of knowledge to support the needs of people who lived at Orchard Manor was not sufficient to meet people's needs.

Risks to people's health and safety were not always identified. Some people required the use of bedrails to ensure that they were safe whilst in bed. There were risk assessments in place for the use of these in some but not all of the care plans. However, the documentation failed to demonstrate why they had to be used or what risks were to be mitigated. We identified the possible entrapment risk of a person using their own headboard and noted that this had not been risk assessed. This meant that people could be left at risk of harm or injury.

We found that medicines were not managed safely. We found that four people were not given the right dose of medicine on some days and medicine administration was not always recorded accurately. Staff did not carry out adequate checks to make sure medicines stored in refrigerators were kept at the right temperature.

Checks on pressure relieving equipment were not robust. We found that out of four mattress settings one was set too high and one set too low. The other two mattresses checked showed one had a dial that had no information to indicate if the setting was correct and the other had an on/off switch. Records indicated that these were not set correctly. If equipment is not set correctly this could be detrimental to a person's skin integrity.

People told us they were not happy with the food. They said the food was 'horrible', 'abominable' and 'food is bland and tasteless'. Other people said the food is variable and some meals were nice. We saw that people waited up to 45 minutes at the table before they were served their meal and we found that the dining experience did not promote a positive experience for people.

Care plans did not always record people's needs and preferences or not always reflect how people wished to be supported. Food and fluid charts were not accurately recorded to show what people had consumed on a daily basis. However care plans did contain information about people's wishes with regard to end of life care and staff were aware of decisions made with the GP and people who were supported. Appropriate referrals to other healthcare professionals had been made where concerns had been identified in regard to people's health.

The quality assurance systems in place were not effective and did not identify, assess or monitor the quality, care and facilities provided to people who used the service. Issues we found during our inspection had not been identified or addressed by the registered provider or registered manager.

Fire safety management within the home required reviewing. The fire risk assessment identified concerns in August 2016 which had not been addressed. We saw no evidence of evacuation training for staff to ensure people would be appropriately supported in the event of a fire. Some doors were propped open with wedges or items of furniture. We have raised our concerns with the fire authority and they have responded to our concerns and carried out a visit.

During the last inspection we raised concerns about the lack of training and awareness of the staff team about the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). We found that staff had still not received this training. Staff were able to talk to us about what they understood by mental capacity, that it is related to specific decisions and that it could be variable. Staff also were able to explain how, on occasion, they had to make decisions for someone and ensure that these were in their best interest.

However, we found that the 'best interest' principle was not always put into practice or evidenced within care plans and risk assessments effectively.

Staff attended annual training sessions in areas such as moving and handling, infection control, health and safety and safeguarding.

The service was clean and free from offensive odours.

The overall rating for this service is 'inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review, and if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medication was not safely administered.

Risks to people were not always identified or assessed appropriately. This meant that people were not always protected from harm.

The service was clean and free from offensive odours.

Is the service effective?

Inadequate

The service was not effective.

The registered manager understood and was aware of the principles of the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) however, these were not consistently put into practice or recorded within the care plan documentation. Staff had not received training on the MCA or DoLS.

Records for food and fluid intake were not accurately completed. The registered manager was unable to evidence what people had consumed.

Checks on pressure relief equipment were inaccurate and could affect people's skin integrity.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

The mealtime experience was not positive or well managed. People told us that they food was horrible, bland and tasteless.

People told us that end of life care was well managed by the staff.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not always record people's needs and preferences or reflect how people wished to be supported. Night report records often stated that people had a good night however these had been written early in the shift before the night had been completed. Records for monitoring people's nutritional intake were inaccurate or not fully completed.

People told us they knew how to make a complaint and were given information about this. Records were in place to show how complaints were managed by the service.

A range of activities were available for people to join in if desired.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance audit systems in place failed to identify, monitor or assess the care and services provided. The management team did not identify or address concerns within the service with regard to people's dignity and respect.

Agency staff did not have access to care plans and risk assessments and therefore had limited information about the people they supported.

Orchard Manor Care Home

Detailed findings

Background to this inspection

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

We undertook a comprehensive inspection of Orchard Manor Care Home overnight on 8 November and also on 21 and 23 November 2016. The first two visits were unannounced.

The inspection team consisted of three adult social care inspectors and a pharmacist inspector who visited on 21 November 2016.

Before the visits we received information of concern about the service. This included concerns that people were being locked in their bedrooms overnight; that staff were starting to get people up at 5.30am; and that nursing procedures were being undertaken without due care and concern for the individual and therefore people who lived at the home could be at risk. This information was passed to the local authority safeguarding team and was included in our planning of the inspection.

During the three visits we spoke with 16 people who used the service, five relatives, and one visiting professional. We also spoke with the registered manager, area manager, operations lead and 19 staff. Staff included nurses, senior care assistants, care assistants, domestic staff, laundry assistants and kitchen staff. We also spoke to both permanent staff and agency staff. We looked at a range of records including 20 care plans; six staff recruitment files; seven staff training records; and records relating to medication, audits and quality assurance. We also reviewed other records relating to the running of the service. We undertook observations throughout the night and day. Following our night visit we spoke with the registered manager by telephone and asked for information on staffing levels, training and induction and personal emergency evacuation plans.

Inadequate

Is the service safe?

Our findings

People and relatives told us that the home used a lot of agency staff and during our night visit we found that half of the staff on duty that night were agency staff. Rotas indicated that this was not a one off situation. People said "They are short of staff, they use a lot of agency staff who are not very good", "An agency member of staff gave me sugar in my tea when I am diabetic" and "On occasions agency staff have asked me to read something when I am blind, they should know these essential things about me." Other comments included "There are too many agency staff", "Too many agency staff that don't know enough about the individual person". An example given was a member of agency staff giving a person a cup of tea who was living with Parkinson's disease and was in need of assistance. This left the person at risk of burning themselves.

Other people said "The staff all seem too busy, run off their feet", "Not enough staff to monitor people", "Not enough staff for the number of people living with dementia" and "Agency staff sitting down while other staff are run off their feet". Throughout conversations with relatives visiting the service there was a general consensus that too many agency staff were being used. There was however an appreciation that the essential use of agency staff was necessary at the present time.

We looked at the staffing levels within the home and reviewed four weeks rosters. We found that there was sufficient staff on duty to meet people's needs. However, we saw that staff were busy with people undertaking task-orientated processes and little time was available for social interaction. During the night visit we found that half of the staff team were from local agencies and they did not know the people they were supporting and did not have access to information about them. The area manager explained that they used agency staff to support the permanent staff to cover the staff vacancies. The human resource manager explained that they had recently employed four new staff, one to work on days and three to work on nights and that they had a further seven staff who would be ready to start in the next two weeks, pending employment checks being satisfactory. They said once these had been completed they would be fully staffed. Although there were enough staff within the home, we found that the deployment of staff and their level of knowledge and experience of the people who lived at Orchard Manor should be reviewed. This would ensure that a good mix of staff was allocated to each unit, rather than one unit having predominately the most experienced staff team.

At our previous inspection undertaken on 25 and 26 April 2016 we identified concerns that people did not always receive their medications safely. A requirement action was issued at the time. Whilst we found that action had been taken further concerns regarding the medicine management were identified during this inspection. An audit had been introduced to check that nurses were handling medicines safely, however, this had only been carried out on one of the five floors within the home.

We observed some people being given their medicines at lunchtime and teatime and saw that nurses administered medicines safely. We looked at the medication administration record sheets (MARs) of 40 out of 87 people living in the home. Records showed that on nine occasions MAR sheets had not been signed to record that the person had taken their medicines. New dose instructions for a person's medicine to thin

their blood were added to their MAR six days late because staff had not acted when the home hadn't received the latest test result. This could have put the person's health at risk. Two other people were prescribed medicines that were important to their health; one person was not receiving the correct dose and the other had missed two morning doses because the medicine was not written on their new MAR. Another person had missed one dose of their antibiotic though it was signed as given on their MAR.

Information as to how each person liked to be given their medicines was kept with their MAR. Any allergies a person had were recorded to protect them from harm. The MARs also stated how often a person needed any medicine prescribed only 'when required'. Nurses recorded the reason for giving a person a 'when required' medicine and the time of administration. These records helped to ensure that 'when required' medicines were given in the right way and not misused.

Some people were given their medicines disguised in their food. Where the person could not make the decision for themselves documents were in place that showed that the person's doctor and family had been consulted and agreed this was in the person's best interest. However, staff told us they had not checked with the pharmacist whether contact with the food or crushing the tablet would change the effect of the medicine. Some medicines become ineffective if mixed with certain foods. Crushing certain tablets can cause side effects as the drug enters the body more quickly. This meant that people were at risk of not receiving their medicines effectively.

Medicine storage rooms were locked, clean and well organised. The temperature in one room was consistently just above the recommended maximum of 25 degrees centigrade. The medicine refrigerators were not monitored properly because the maximum and minimum temperatures were not recorded: This meant there was no record to show medicines inside were kept at the right temperature throughout the day and night. If medicines are not kept within the temperature range specified by the manufacturer they may become less effective or even harmful.

Controlled drugs (medicines subject to tighter controls as they are liable to be misused) were stored in cupboards that complied with the law. The home audited (checked) controlled drugs every month. The stock balances of the sample of controlled drugs we checked were correct. However we found two errors in the records in one controlled drugs register.

The receipt and disposal of medicines was recorded so that medicines could be accounted for and the home had some good systems for managing this. Medicine policies were up to date and covered all aspects of handling medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have appropriate procedures in place for the safe management of medicines.

People had a range of risk assessments in place which outlined the specific risk and the action to be taken to minimise the risk to the individual. However, we saw a bed in use that had a metal head and foot board where the gaps were wide enough to pose a potential entrapment risk to the person sleeping in it. There was no risk assessment carried out to identify these risks or the capacity of the person to accept these risks. Some people required the use of bedrails to ensure that they were safe whilst in bed. There were risk assessments in place for the use of these in some but not all care plans. Risk assessments should be in place for all people who were assessed as requiring the use of bedrails.

A number of people had motion sensors in place to alert staff to their movements. This was so staff could

provide supervision and support when required. Risk assessments and care plans indicated when these were in place and the reasons why. However, the registered manager failed to ensure that the effectiveness of these was reviewed. For example, one person had the sensor positioned so that any movement to her legs or even the wobble from a table set off the alarm. Staff were slow to respond when her alarm went off as they had become complacent to it and told us it was very rarely set off due to her getting out of her seat. Consideration of other equipment such as a pressure cushion may have been more effective.

When we last visited the service we found concerns with the pressure relief mattresses. The registered manager did not have checks in place to ensure the pressure was set at the correct level for each person. We found that an audit had been completed and that monthly checks were carried out by the handyman. We looked at the settings for a sample of four mattresses and found one set too high and one set too low. Of other two mattresses one had a dial that had no information to indicate if the setting was correct and the other was an on/off switch. If equipment is not set correctly this could be detrimental to a specific service user's skin integrity. We discussed this with the area manager who agreed to look at the mattresses that had systems in place which were difficult to accurately regulate.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have adequate systems in place to maintain people's safety.

One of the concerns raised before the inspection was that people were being locked in their bedrooms overnight. During our visits we found that only people who wished to lock their doors had these locked. These people had the ability to get out of the room unaided if they so wished. During our night visit most of the bedroom doors were left wide open overnight which did not afford people dignity or privacy overnight. We tried a sample of bedroom fire doors and they were found not to close properly to ensure a flush seal. Some doors were found to be kept open with wedges, a bedside cabinet, an over bed table, and a linen basket. If a fire occurred at night these doors would not close automatically due to the obstructions in place. One bedroom had a faulty mechanism and the press release was not working and the fire door at the bottom of the stairs in one section did not shut tight when the mechanism was released.

We highlighted our concerns to the local fire authority and they visited the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider restricted people's movement unlawfully.

We saw that the laundry room door was left open on three occasions with no members of staff in there. There were Control Of Substances Hazardous to Health (COSHH) products stored within unlocked cupboards. These products included washing detergent and softeners which could be harmful to people if ingested or could cause irritation on people's skin.

The two small new lounges which have four doorways leading off each were extremely cold and draughty during the daytime. The radiators in one of the lounges were cold to the touch; one small radiator was in the other lounge but was insufficient to heat the area. There was no evidence that staff were monitoring the temperature of these rooms. It was noted that nobody chose to sit in these areas throughout the daytime inspection process. This was brought to the attention of the area manager at the time.

We looked at the Personal Emergency Evacuation Plans (PEEPs) for people who lived at the home during our night visit. We found that information about the level of support each person needed in the event of an emergency was documented. This was inaccurate, for example, six people had moved bedrooms but their information had not been updated. Also when we checked four rooms which identified the individual living

there we found those rooms were empty and unused, and that six rooms that were designated empty had people sleeping in them. We found that 50 out of 87 people living in the home were rated as medium or high risk and would need two or three staff to support them in the event of an emergency. Given that staff were not fully conversant with the evacuation processes and procedures and that crucial documentation was not accurate this put people's safety at risk. Following the inspection we requested a further copy of the PEEPs matrix which had been updated.

We looked at the registered provider's fire risk assessment which had been completed in August 2016. Actions identified had not been implemented by the registered provider or registered manager which meant that people were at risk of harm should a fire break out in the home.

The registered provider had a fire safety policy which stated that fire drills would be undertaken every six months; however, records demonstrated that these had not taken place. Staff told us they had not been involved in any fire drills. We found that staff had undertaken fire safety training and had been shown how to use the evacuation chair and fire equipment. They had not carried out a simulated evacuation of their work area or building and that their knowledge of what to do in the event of a fire was limited. There was inconsistency in the awareness of fire safety between the day and night staff. Day staff had a clear understanding of the fire processes and procedures needing to be followed in the event of a partial or full evacuation. They described the use of appropriate equipment and the fire training they had completed. The night staff had a poor understanding of the fire processes and the procedures to be followed in the event of a partial or full evacuation. Agency staff had not undertaken essential induction training that covered fire procedures. All staff spoken with stated they had never undertaken a planned or unplanned drill at any time of the day or night to the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not maintain people's safety.

The registered provider had a range of policies and procedures in place with regard to safeguarding people from abuse. The registered manager confirmed that copies of the local authorities safeguarding policies and procedures were available in the office which we saw. She was aware of how to make a referral and had notified CQC as required by law. Most staff spoken with had a basic understanding of safeguarding as well as whistleblowing. They described the process they would follow in each of these events.

Staff recruitment files were well presented and information was easily accessed. We found that staff had completed an application form and attended an interview. The registered provider had undertaken all appropriate recruitment checks prior to staff working in the home. This meant that the registered provider had appropriate checks in place to ensure staff employed were suitable to work with people at the service.

We saw that accidents and incidents were reported appropriately and records kept with details noted within care plan documentation. The registered manager told us that she worked with the falls prevention team at the local authority as needed and that accidents and incidents were audited on a monthly basis.

When we last inspected the service we identified concerns about the cleanliness of some equipment and the premises. We found that improvements had been made and saw that the home was clean and free from offensive odours. One person said "The staff clean my room regularly."

We saw certificates which showed there had been routine servicing and annual inspections in respect of the gas and electrical installation. Equipment such as hoists had been regularly checked. Safety checks had been carried out to the nurse call and fire alarm systems. This meant that the registered provider had

systems in place to ensure that the building and equipment remained in good working order and safe.

Inadequate

Is the service effective?

Our findings

People told us "I have to direct agency staff to my routine but I am lucky I can do that", "One or two of the staff get a bit cross sometimes. I don't know anyone's names" and "The staff are very nice."

People told us "The food is horrible", "The food has improved over the last week or two and it is okay", "The food is abominable", "You order one thing and get something else, the food is bland and tasteless" and "The food is variable, there is always a choice." Other comments included "Some meals are nice but some are not so good", "My food is nearly always cold. I have my meals in my room. Recently I had sausage and mash, the sausage was warm however the mash was icy cold and felt like it had just come out of the fridge". The area manager did come to offer me an apology when I complained.

A relative told us there is always plenty of food and drink. Another relative told us their husband was on a soft diet, they felt the food was not always palatable. An example given was that he was served mashed potato with spaghetti in tomato sauce. They stated it looked most unappetising on the plate. A family member that was visiting stated the food is excellent and they had not had any concerns about this. They said they were always offered food and drink when visiting.

During the lunchtime the activities coordinator actively communicated with all people sat within the dining room. They were friendly, warm, communicative and interactive as well as being inclusive. One person chatted to her friend sitting next to her and appeared to enjoy the mealtime experience overall. One person dozed while waiting for their meal as they had been waiting in excess of 45 minutes.

The dining tables were laid with cloths, napkins and spoons. Condiments were not placed on the table until they were asked for. Knives and forks were placed on the table after meals had been put down. Overall people commented that the meal was okay. Staff offered tomato sauce when it was requested however tartar sauce was on the menu but was not offered. The member of staff offering drinks to people was very curt in their manner. They did not smile or demonstrate any warmth towards the people they were serving. We heard the staff speaking to people in an inappropriate manner such as "She's a soft" meaning the type of diet they needed. This did not promote the dignity of the individuals involved.

We saw two people supported to eat their lunchtime meal by a member of staff. Whilst the interactions were appropriate and sufficient time was given for the person to eat their food the member of staff stood over the person throughout the mealtime experience rather than sitting side-by-side.

There was a three-week menu plan in place which was a traditional menu that included meat, fish and vegetarian options throughout the week. People had a choice of two meals and the cook told us that the main meal had been moved to the lunchtime as people preferred that. A new autumn and winter menu had been prepared and had been discussed with people at the residents meeting in September 2016 (records confirmed this). The service had retained their five-star environmental health rating. Fridge, freezers and hot food temperatures were taken and appropriately recorded. Sheets for recording people's meal preferences were circulated to each unit daily and some people were noted to require 'finger foods'. This meant that

people who could not eat a full meal were offered food that they could pick up with their fingers such as breaded fish or chicken pieces, chips, sandwiches, toast, pieces of fruit, biscuits, cake etc.

During the last inspection we raised concerns about the lack of training and awareness of the staff team about the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). We found that staff had still not received this training. However, staff were able to talk to us about what they understood by mental capacity, that is related to specific decisions and that it could be variable. Staff also were able to explain how, on occasion, they had to make decisions for someone and ensured that these were in their best interest.

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

We checked whether the service was working within the principles of the MCA 2005, and whether any conditions or authorisations to deprive a person of their liberty were being met. The registered manager was aware of the principles of the Act and how to determine people's capacity. The registered provider had up to date policies and procedures in regard to the MCA 2005 and DoLS. The registered manager explained that they had applied for DoLS applications for people whose liberty was being restricted.

However, we found that the 'best interest' principle was not always put into practice or evidenced within care plans and risk assessments. Assessments undertaken by the service prior to commencing the support did not determine if the service user had given informed consented and whether decisions had been made in their 'best interests'.

Prior to the inspection it had been reported and confirmed that people's freedom in the home had been unlawfully controlled. For example, bedroom doors had been locked when people were either inside or outside of their rooms. We spoke with staff who informed us that sometimes the doors had been locked to stop people going into each other's rooms or to keep people safe. We were told that when people wanted to go back to their rooms they would ask staff to let them in. Staff had not considered whether a person had the mental capacity or physical ability to unlock their doors from the inside. We looked at some of the DoLS applications that had been made by the registered manager to the local authority and saw this had not been considered.

Following a visit from the local authority, the registered provider had started to consider whether doors were to be kept open or closed in line with a person's wishes or best interests. Staff told us that during the day doors were left open unless someone expressed a wish for it to be closed: this was so that staff could keep a close eye on people especially where there was a risk of harm.

Some people required the use of bedrails and the registered manager had identified these as a restriction and requested an assessment as to whether this reached the threshold for consideration as a DoLS. The registered manager did not however demonstrate a person's capacity to consent, what other options had been considered and whether the use of bedrails was the least restrictive option.

This was a breach of Regulation 12 of the Health and Social Care Act 2018 (Regulated Activities) Regulations

2014 because the registered provider did not have suitable arrangements in place to obtain and act in accordance with the consent of service users.

The registered provider had a training matrix which showed the training staff had completed. The registered provider employed a training manager to ensure staff undertook induction and appropriate training for individual staff member's role. Each staff member undertook an annual refresher course which the training manager told us was a day course which looked at key areas and gave staff updates on these areas. However, we found that although staff had undertaken training in fire safety and safeguarding they had limited knowledge and understanding in these areas.

Agency staff told us that they had received a basic induction into the service on their first day. Following our first visit the registered manager provided information which included an agency induction checklist. The induction included information on fire safety, detailed information on how to access the computer system, the call bell system and plan of the home. However, on further discussion with the registered manager it was evident that this checklist and induction process had not been completed with the agency staff. The records we reviewed during our visit demonstrated that agency staff did not have a robust induction to ensure they could meet people's needs. Agency staff confirmed that a basic induction included being shown around the home, introduction to staff on duty, introduction to some of the people who used the service and brief details of the people's needs on the unit they would be working on. All this information was given verbally which meant that staff did not have written reference documents available to them.

Permanent staff told us that they had received a basic induction at the beginning of their employment; however, in five out of seven records reviewed these were not completed.

Annual appraisals should have taken place once a year in line with the company policy. Staff told us they did not have regular appraisals and did not always know who their supervisor was. Records supported this. There was not a clear understanding of clinical supervision for the nursing staff and who would undertake this. The area manager explained that supervision sessions had been undertaken on an ad-hoc basis in the past. They had set up a new system which was currently being trialled and would be implemented for all staff in January 2017. We saw documentation which showed some individual and small group supervision sessions had taken place. These showed areas that were discussed, actions to be taken (if required) and supervisee comments.

This was a breach of Regulation 18 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014 because the registered provider failed to ensure that staff received appropriate support, supervision, training and induction to enable them to carry out their duties.

People's health care needs were recorded in their care plans. We saw that visits from professionals were recorded and where changes were needed to care plans this was undertaken. Visiting professionals included the GP, nurse clinician, district nurse, community psychiatric nurse, physiotherapist, tissue viability nurse, optician and social worker. We spoke with a visiting professional who said they had seen improvements in the home and that recent changes had been beneficial. They said that the home caters for people with complex needs and that they had a good rapport with the staff.

Requires Improvement

Is the service caring?

Our findings

People told us "Staff look after me okay", "Staff are all right, half and half. Some are better than others", "The staff are all right, some of them are lovely, very nice", "The staff are okay" and "The staff do not look after me, I can do most things from myself. I do not find the staff caring."

People were not afforded privacy and dignity in their lives. We saw that many bedroom doors had been left open with people partially dressed or in their nightwear in view of other people walking in the hallways. This may lead to people feeling vulnerable or uncomfortable within their own home. Staff told us that the doors being left open were the person's choice or that it was to enable the staff to monitor them. Records showed that this was not recorded as the person's choice. Following our night visit staff had started to review and update records with the involvement of the person and family members in the decision about doors being left open at night.

During the morning we also saw that a person walked down a corridor past four members of staff wearing soiled nightwear. All the staff members ignored the person and eventually the area manager supported them back to their room. Another example included observations of staff standing over people when assisting them with their meal, rather than sitting next to them.

We saw evidence of unsafe practice. A person was observed being repositioned in their chair within the dining room by two members of staff lifting them under their armpits. Staff had up to date training in moving and handling, however, this was not an appropriate way to reposition a person and could lead to an injury being caused. Also on two separate occasions staff were seen pushing people in wheelchairs with lap straps undone and no foot plates in place. These issues were brought to the attention of the area manager who said they would address this. The registered provider should re-evaluate their training and staff procedures to ensure that the Health and safety in care homes guidance produced by the Health and Safety Executive (HSE) is followed and that staff do not use unsafe techniques or practice.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered provider had not ensured that people were supported safely by the staff team.

Staff put in place a 'do not disturb' sign when they were undertaking personal care in a person's bedroom. The sign was placed on the person's door and the door remained closed during personal care. However, this system was not consistently used throughout each day of our visit. Some staff were observed knocking on people's doors before entering however not everybody was observed doing this and staff did not always wait for a response before entering.

The dining experience did not promote a positive experience for people. Some people were sitting at the table for up to 45 minutes without being offered a drink or food. Staff had put protective clothing such as plastic-backed "bibs" on people to protect their clothing. People were not asked if they wanted protective clothing on. We saw that where people had meals in their bedrooms, and needed support to eat these, the meals were left on a tray and the hot meal was covered with foil. However, on returning to the room 30

minutes later the tray was in the same place and the staff member to support them had not arrived. This meant that the food had been sitting there for half an hour and once the staff member arrived this was not checked to ensure it was hot and suitable to be eaten.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered provider had not ensured that people were supported with dignity and respect.

The registered provider had policies on end of life care and advanced care planning and we saw that people had care plans in place which considered their end of life wishes. End of life best interest meetings had been held with the person and their family regarding do not attempt resuscitation (DNAR) being in place. Capacity assessment had been undertaken by the GP and staff were aware that people's wishes were documented in the care plan. Information about who to contact in the event of the person's death, their preferred funeral arrangements and wishes were documented. The area manager explained that a full end of life care plan would be completed as needed. One relative who had recently lost a family member said they were very impressed with the care and support their relative and wider family members had received from the staff team. They said "The care for my parent and the family was above and beyond" and "I was very impressed with the care overall and for us as a family."

The service user's guide was being updated following the changes within the home from five units to two. The statement of purpose included details of the registered provider and registered manager, the aims and objectives and the type of care provided. Other information on the noticeboard near the office included a copy of the last CQC inspection report with the latest ratings displayed, copies of the current menus, minutes of residents meetings and a copy of the statement of purpose.

We saw that information about advocates was included on the noticeboard. This included how to contact Age Concern, CAB, Cheshire Centre for Independent Living (CCIL) and Independent Advocacy Service. There was also information on how to contact the local IMCA (Independent Mental Capacity Advisor) and DoLS (Deprivation of Liberty Safeguards) Advocacy Service. Advocates are able to offer independent support to people, to ascertain their wishes and feelings and to ensure that these are taken into account by the registered manager. The area manager said that currently people who lived at the home were not using these services.

People's confidentiality was maintained. Records that contained personal information were stored on the computer system which was password protected. All permanent staff had access to the system however only senior staff could add to or alter the records. Care records contained the relevant paperwork for those people who did not want to be resuscitated in the event of death. A board in the main office showed who had this in place and was easily accessible if needed.

A range of compliments had been received from family members about the care and support received by their family members. A list of staff members who had been mentioned were noted and included compliments such as 'a caring and kind nature', 'helping when needed' and 'helpful and welcoming'. These were displayed on the noticeboard.

Inadequate

Is the service responsive?

Our findings

People told us that they knew how to make a complaint and that they would speak to a staff member or the registered manager if they had any concerns. A relative told us that the registered manager had responded to concerns they raised. They described that on one occasion she had visited her family member to find them dressed in someone else's clothes. They understandably found this very distressing and the registered manager addressed their concerns. We noted that the registered provider had a complaints policy and procedure. The policy detailed how concerns would be responded to and inlcuded information about other people that could be contacted in the event the concern was not satisfactorily resolved. The registered manager maintained a monthly tracker which contained an overview of complaints received, investigation plan and findings.

Care plans were written in a personalised way and people and their families had contributed to the information included. However, these did not consistently reflect the care people received. Care plans covered a range of assessments and monitoring tools. We found that within some areas of the care plan instructions had been given which had not been completed. For example: one person it stated that monthly blood pressure readings should be completed, however, this had not been recorded. Another person's door was wedged open with a piece of furniture. We were not able to speak with the person but were told by staff that this was their preference; however it was not recorded within the care plan.

One person had been identified with weight loss and the registered manager had ensured that advice had been sought as to further management and prevention. A review of the person's care plan had indicated that they required encouragement, fortified foods and finger food/snacks throughout the day. On the day of the inspection, the person was served a full hot dinner (both main and desert) which was taken away untouched. They were not offered finger foods or snacks as an alternative at any point of the day. Another person was diabetic and staff were not able to monitor their blood monitoring as they were needle phobic. There was no further information in the care plans to indicate to care staff how to observe for signs and symptoms that may indicate that these were outside of a normal range. Although the registered provider employs nursing staff, the majority of the care and general support tasks are undertaken by senior care assistants and care assistants. It is these staff who would primarily be supporting people and signs and symptoms could be of benefit to help them in the monitoring of some service users.

Records to assist staff in monitoring food and fluid intake for people were inaccurate or not fully completed. The record showed the total recommended fluids for each 24 hour period as 1500mls and the approximate volumes for cups and mugs. However, records did not show the quantity of liquid offered or taken and where it was recorded this had not been totalled for the day. This meant that checks were not in place to ensure people had sufficient hydration throughout the 24 hours. Some food had been offered to people who preferred 'finger foods'. Frequently these foods had been recorded as 'refused' and no indication was made that other food was offered or taken. This meant that people with specific dietary needs were not being taken into account.

This was a breach of Regulations 12 and 17 of the Health and Social Care Act (Regulated Activities)

Regulations 2014 because people were not protected from the risks of inadequate nutrition and hydration and adequate records were not maintained.

Daily day and night records showed support people were given with personal care, their health needs and general well-being. Records also indicated if diet and fluids had been taken, and details of any visitors. However, we noted that the computer system also recorded the time the record was written. In particular the night records were often completed between 2am and 4am. We sampled a range of records which stated "Had a settled night……very sleepy", "settled night……..no concerns, seems in a good mood - all okay", "checked regularly. No concerns." Within two different people's records we found the same details "settled night……...appears to have slept well". These records indicate that people had slept well throughout the night, yet were made part way through the night. This meant that records may not be accurate. We spoke to the area manager regarding this and they agreed to address this concern.

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered provider did not have effective systems in place to monitor the safety of care provided.

We saw some activities being undertaken during the visit which included decorating Christmas trees and a very interactive nostalgia session. We had mixed comments about the activities available. One person said "There are no activities or outings. I am bored and I have nobody to talk to". However, observations on the days of inspection and findings showed this was not the case. Other people commented "The activities are very good but I've always been a loner so don't join in very often." We saw that records were kept of activities undertaken and where people preferred to stay in their bedrooms, staff had spent time with them to help alleviate social isolation. An activity board located in the foyer showed forthcoming activities such as quizzes, reading the paper, reminiscence sessions, arts and crafts, games and visits from the tuck shop. We noted that there were weekly visits from the hairdresser and a programme of activities had been produced on the run up to Christmas that included the local bell ringers; visiting singers and entertainers; and quarterly residents and relatives meetings. The activities coordinator stated they attended family meetings and also chaired residents meetings.

Inadequate

Is the service well-led?

Our findings

People and relatives told us that they knew who the registered manager was and that she was approachable. Comments included "I know who the manager is" and "I would speak to the manager if I had any concerns." People and relatives also told us that they thought too many agency staff were being used at the home. They said there was "Not enough staff to monitor people" and "Not enough staff for the number of people living with dementia."

A registered manager was in post that had been registered with the Care Quality Commission (CQC) since December 2014. The registered manager was supported by the area manager, HR manager, operations lead, nurses, care workers, and other ancillary staff.

Staff told us about the culture within the service and gave examples of how they were expected to help people get up in the morning or get ready for bed in the evening. They said there was an expectation that a certain amount of people would be ready for the next shift of staff due on duty.

Questionnaires for visitors to complete had been available at the front desk, however information from these was not available at the time of the inspection. One person said her husband had lived at the service for two years and she had never been asked for feedback. The last questionnaire sent to people was in March 2016. Information from the questionnaire responses had been collated and people said their overall impression of the home was "Satisfactory", "Most of the time good", "Quite nice", "We like it very much" and "Very good and impressed with the care and attention – thank you."

The registered manager told us they were preparing a new questionnaire which would be distributed shortly. Resident and relatives meetings were held quarterly and copies of the minutes were displayed on the noticeboard. The last residents and relatives meeting was held in September 2016. These meetings gave people and their family members the opportunity to express their views and make decisions that may be required in the service.

Questionnaires were also sent out to the staff team. This was last completed in February 2016. Comments included "I am satisfied with my training", "I feel confident in my role", "Its hard work here, but I like my job" and "The staff team work well together." A new staff survey had been recently sent to staff team.

At the previous inspection we raised concerns that the registered provider's quality assurance systems had not identified issues we raised at that inspection. Whilst some improvements had been made these were not sufficient and we raised continued concerns regarding the robustness of the quality assurance audit systems.

Although a range of audits were undertaken on pressure area care, medication, care records, maintenance, environment, infection control and accidents and incidents we found that these failed to identify or monitor risks to the quality or safety of people who used the service. Examples included: the pressure relief mattress checks to ensure the settings were appropriate for the person's weight showed inaccurate information. We

checked a sample of four mattresses and found inconsistencies with the record. Another example: Where medication audits did not highlight concerns we raised at this visit with regard to missed medications and staff signatures, and another example: that the environment audits did not highlight the potential risk of entrapment by a headboard in a person's bedroom. We found that the fire risk assessment produced in August 2016 had an action plan with actions to be taken which had not been addressed. This meant that information within the audits was ineffective, inconsistent and did not identify potential risks to people.

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered provider did not have adequate systems in place to assess, monitor and improve the quality and safety of the service provided.

A nurse showed us the handover book that was used for each unit. They said the information included a photograph of each person; details of their medical history; mobility requirements; and a brief description of how the person had been during that day and night. However we found 17 records did not have any information on them and 10 records were partially completed. Information was recorded about a person who we found out didn't live in the home anymore and two people had moved rooms but their information had not been updated. This meant that staff did not have up to date and accurate information about the people who lived at the home.

Night visits had been carried out by the area manager and a senior care assistant. We saw that on one record that "lots of doors were open on fire detachment devises" but no information had been completed for action to address the issue of people's dignity and privacy being compromised. One report stated "The home is run well and there were no concerns with resident's safety" however; we found concerns with people's safety during this inspection. Therefore records of these visits failed to identify potential risks to the quality or safety of people who lived at the home.

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered provider did not maintain accurate and complete records in respect of each person.

Some staff spoken with stated they did not have regular team meetings, however our findings showed that staff meetings took place with records kept. The last staff meetings were held in September 2016.

The registered provider had a wide range of policies and procedures which related to the service provided. These included policies on moving and handling, infection control, medication, safeguarding, confidentiality and data protection. Staff told us that they had access to the policies which were kept in the main office.

The registered provider had a business continuity plan in place. This contained information about what to do in the event of a loss at the service such as accommodation, utilities, IT, staff, and severe weather disruption. It also included the contact details for senior staff and copies of log sheets to be completed in the event of an incident.

The registered manager was aware of the incidents that needed to be notified to CQC. These are incidents that a service has to report by law. We saw that notifications had been received shortly after the incidents occurred which meant that we had been notified in a timely manner.

The registered provider had displayed their ratings from the previous inspection in line with the Health and Social Care Act (Regulated Activities) Regulations 2014: Regulation 20A.