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Acacia Lodge - London

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 was unannounced and took place over two days on 11 May 2015 and 15 May 2015. When we last inspected the service in May 2014 we found breaches in standards relating to infection control and cleanliness and records.

Acacia Lodge provider accommodation with personal care for up to 32 older people, some of whom have dementia and physical disabilities.

The registered manager has been absent since September 2014 and the service is being managed by an interim manager, who told us that they would be applying to be the registered manager in the near future.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had submitted a notification of this change in September 2014 informing us that the registered manager would be absent for one month, however the registered manager is still currently absent.

Our last inspection in May 2014 highlighted breaches in cleanliness and infection control and accuracy of records.

Summary of findings

We asked the provider to take action to make improvements. We received an action plan from the provider stating that these actions would be completed by end of January 2015. We saw that although some of these actions had been completed, the actions related to records had not been completed.

At this inspection we found improvements in the way the service managed infection control. However, we found care records were not always accurate and up to date, consent to care and treatment, and medicines were not appropriately managed and unsafe premises.

People were not always treated with respect and their dignity, privacy, choice and independence were not always promoted. At mealtimes people's dignity was not always maintained and choice was not always promoted.

Training, supervision and support were not effective to ensure staff had the right knowledge and skills to carry out their roles and responsibilities.

People were not provided with regular access to meaningful activities and stimulation, appropriate to their needs, to protect them from social isolation, and to promote their wellbeing.

Deprivation of Liberty safeguards (DoLS) had not been appropriately applied. These safeguards provide legal protection for adults using services who do not have capacity to make their own decisions and require constant supervision by staff. Applications had not been made for appropriate assessment and authorisation by professionals for a best interest decision on any restriction on their freedom and liberty.

The management of the service was inconsistent following a period of change. This had led to the poor guidance for staff and unsafe practices.

People did not always receive the encouragement they needed to eat and drink well. There were enough staff to meet people's needs but we found that the delegation and organisation of their duties did not always mean people received the support they needed consistently and in a timely way.

We found that there were a number of breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- 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 take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

People's risk assessments did not always reflect their current health needs.

People did not consistently receive their medicines safely and as prescribed. We found some medication administration charts (MAR) and staff medicines training was not up to date.

Staff knew what to do if they had concerns about abuse. However, not all staff were aware of the external authorities to report to.

People were protected from the risk of infection because the provider had systems in place to ensure the environment was clean.

Is the service effective?

Inadequate

The service was not always effective.

Although some staff received training in the MCA and DoLS this was not effective. Staff did not understand the MCA and the impact on people who may lack capacity to make decisions about their care.

Staff received supervision and support, however this was not consistent. Staff training had been ineffective in areas such as risk assessments and medicine management.

People's nutritional needs were met by the service.

People were referred to other healthcare professionals to assist the service with meeting their individual needs.

Is the service caring?

Inadequate

The service was not always caring.

Although relatives told us that their relative was well cared for and treated with dignity and respect, we observed that staff did not always treat people with dignity and respect.

People's relatives were involved in their care

Is the service responsive?

Inadequate

The service was not always responsive

People did not have access to meaningful activities or stimulation. There were no planned activities and we saw very little activities taking place on the day of our inspection.

People's individual needs were not always met by the service.

People and relatives knew how to make complaints. Relatives told us that they were able to make a complaint and felt the service listened and acted on their concerns.

The service supported people to maintain contact with family and friends who were able to visit anytime.

Summary of findings

Is the service well-led?

The service was not well-led

People were not protected from the risk of poor care and treatment because systems in place were not effective in monitoring the quality of the service.

People and relatives were comfortable raising issues about the service and were confident they would be addressed and improvements made.

Inadequate

Acacia Lodge - London

Detailed findings

Background to this inspection

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

This inspection took place on 11 May 2015 and 15 May 2015 and was unannounced.

The inspection team consist of the lead inspector, a specialist advisor who is also a pharmacist specialising in medicines management in care homes and dementia care, a specialist advisor specialising in nursing care, including incontinence care and pressure ulcer management, an expert-by-experience whose area of expertise is dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we gathered and reviewed information we currently hold about the service, this includes statutory notifications received since our last inspection in May 2015 and any other information received about the service, for example feedback from stakeholders.

We observed care to help us understand the experiences of people who could not talk with us. We spoke with 10 relatives, eight staff, including the provider, acting manager, senior care staff care staff, chef and domestic staff. We reviewed care records and risk assessments for 11 people using the service. This included, food and fluid charts and Malnutrition Universal Screening Tool (MUST) a screening tool used to identify people who are malnourished and at risk of malnutrition (under nutrition), or obese. We reviewed staff training records and personnel files for five staff and supervision records for 14 staff.

We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with the local authority quality team We contacted a number of healthcare professionals, but were unable to speak with any.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person said, "I like it here, I have a room to myself, the carers are nice people, oh yes I feel safe and I have a friend." Another person said, "Not much can happen to us here." Relatives told us they felt their relative was looked after well and safe. One relative told us, "[relative] is well cared for and in a safe place."

However, we found medicines were not managed safely because the service was not following current and relevant medicines guidance. We found issues with how medicines were stored, used and recorded. We found staff administering medicines had received medicines training, however we judged that this training was not adequate because of the issues with medicines that we found. Medicines audits were not effective as the issues we noted had not been identified prior to our inspection. Therefore we were not assured that safe and effective systems were in place to ensure that people consistently received their medicine safely as prescribed.

We found the room where medicines were stored was not adequately monitored. We found the environment cramped and untidy with disused medicines inappropriately disposed of in a black plastic bag. This included discarded tablets and used capsules, also sensitive information pertaining to people living at the service. The disposal of medicines is regulated by law in order to protect the environment. If medicines are put out with normal rubbish and placed in a land-fill site, they could fall into the wrong hands and put people at risk of harm. The acting manager did not know why this had happened. The room temperature was recorded in a designated book, but there was no method for cooling the room down or procedure to follow. On the day of our inspection the temperature was recorded as 19C however at 9.30am we saw the temperature was at 26C, by 11.30am this had reached 28C. This was above the recognised accepted limit for medicines which should not be stored above 25C. This temperature reading had been confirmed by the acting manager who was present at the time. This put people at risk of receiving medicines that are ineffective or might do them harm. On the day of our inspection we found the room where medicines were stored locked, however we noted that the keys to access the room were shared between domestic and care staff who were not responsible for management of medicines.

The room contained a fridge which we found unlocked. We saw that the temperature was monitored daily and recorded as being between 2C and 8C therefore within acceptable limits. We found eye drops which were stored on the medicines trolley currently in use were all without dates of opening, therefore there was no way of knowing if they were within their expiry date and safe to administer.

We found medicinal and emollient creams were stored in open access on the bedside table for one person who also shared a room with another person living at the home. This put people at risk of accessing medicines inappropriately.

Senior carers told us that they were responsible for the ordering of monthly medicines and were able to evidence that copies of some prescriptions for monthly medicines were stored in the medicine room. However there was no clear audit trial or checking procedure of medicines ordered. This lack of clear processes led to one person being without their prescribed pain relieving medicine for 20 days until this was identified on the first day of our visit.

We asked staff responsible for administering medicines about the use of covert medicines. In relation to the open capsules found in the general waste, we asked if anyone living at the home received their medicines covertly (medicines disguised in food or drink). They confirmed that no one living at the home had covert medicines. However, we were told by one staff member that they occasionally administered one person's prescribed capsules by adding them to the person's breakfast cereal to ensure he had taken them. However, we found no evidence in the person's care plan to support the administration of medicines covertly or a risk assessment to ensure other people living at the service did not accidently ingest the food containing medicines. This person did not have a mental capacity assessment or best interest meeting to determine their capacity to make decisions about their care.

National Institute for Health and Care Excellence (NICE) guidelines 'Managing Medicines in Care Homes' states that all care settings should have a written policy for the safe disposal of surplus, unwanted or expired medicines. When care staff are responsible for the disposal, a complete record of medicines should be made and they must be stored securely in a tamper-proof container until collection.

We found [Controlled drugs (prescribed medicines that are usually used to treat severe pain) were not appropriately managed. A supply of a controlled drug dispensed for one

person in April 2015 had not been entered into the controlled drug register and was found in a cardboard box with general medicines awaiting return to a pharmacist. This medicine was subject to the Misuse of Drugs Act and therefore requires specific safe storage requirements.

The home stored a variety of homely remedies (non-prescribed medicines). The homely remedies used for external purposes, such as creams were in date but there was no information relating to the opening date. We found that the homely remedies record book recorded that the last administration of a homely remedy was in November 2014 and that the current balance of this medicine left in stock was 10 capsules, we demonstrated to the acting manager that there was only one capsule left, therefore we could not evidence that homely remedies were appropriately managed.

The medicine cycle and current records started on the day of our inspection on 11 May 2015, however there were a number of people on respite whose records were for a longer period of time therefore we carried out dose reconciliation on some of these records. These were confirmed with staff responsible for administering medicines and the acting manager who was present.

We reviewed medication administration records (MAR) charts for eight people who used the service. We counted a sample of medicines in stock and checked these against medicines records, and there were a number of discrepancies in six out of the eight MAR charts reviewed. For example, we found a hand written MAR chart for one person with no warning label information in relation to maximum number of tablets in a dose and maximum number of doses to be taken in 24 hours. This had no signature documenting who had written or checked it. In another example, we found the person had been prescribed 12 tablets which had been recorded as given between 27 April 2015 and 8 May 2015, however, staff had recorded this as given on 10 and 11 May 2015 even though there was no stock available. We noted that staff had recorded on the back of four people's MAR charts the letter 'W' for withheld. Despite medicines being prescribed, staff had decided whether people should be given their medicine, they told us that this was because people did not need it. We found no evidence of a review of medicines by a healthcare professional or protocol for withholding medicines. Therefore people were not receiving medicines as prescribed. A fourth person prescribed a liquid medicine labelled as give a 0.625ml dose when required for pain. There was no oral dose syringe available and staff were estimating the dose using a domestic metal teaspoon. This put the person at risk of receiving the incorrect dosage.

We saw some risk assessment were in place for falls, manual handling, Waterlow and MUST. However, we found these were not always updated or not in place. There were no risk assessments carried out for the use of bed rails. Capacity and understanding of the purpose for bed rails had not been considered for people living with dementia. This meant that the decision for their use may not have been in the individual's best interest and could place them at risk of injury. Staff had not recognised the potential impact on people or explored alternative and more suitable options. We found two people prescribed medicines used to prevent heart attacks, strokes and blood clots did not have risk assessments in place in relation to the risk associated with taking the medicine and of side effects. One person self-administering medicines was found to have these stored on the side in his bedroom for self-administrating. Staff could not evidence how this process was safely managed. There were no risk assessments in place to ensure other people were not put at risk of accidently taking the medicine. Staff were signing the MAR chart indicating they had administered the medicines.

These were breaches of Regulation 12 of the Health and Social Care Act 208 (Regulated Activities) Regulation 2014.

People were not always protected from the risk of abuse. Although staff knew what constituted abuse and the signs to look for, not all staff knew the external authorities they can report their concerns to. They were aware of the need to report anything that they observed to the senior person. Staff told us that they had not received safeguarding training. One member of staff said that they last received training three years ago, another told us they had not received training in this employment.

This is a breach of Regulation 13 of the Health and Social Care Act 208 (Regulated Activities) Regulation 2014.

People were protected from the risk of acquiring an infection. Since our inspection in May 2014, we saw that the home had made some improvements to the standard of cleanliness at the home. There was an infection control audit which covered the general environment, however, records showed that the last audit took place in December

Is the service safe?

2014. On the day of our inspection we saw cleaning going on throughout the day. We saw that the service had introduced a daily cleaning check which was located at the back of the toilet door, those seen were completed and up to date. Staff cleaning the home had worked for the service for some time and understood the importance of keeping the building clean. However, we noted on the ground floor unpleasant odour of urine. The acting manager told us that there was a cleaning programme to deep clean all curtains and blinds at the home.

There were hand dispensers in communal areas and those checked were full, most did not have hand hygiene information to give staff guidance on appropriate hand washing. Hand washing signs were above sinks in the communal bathrooms and soap and paper towels available. There was a good supply of gloves and aprons and staff confirmed that these were available.

All the relatives we spoke with told us that they felt the environment was clean.

There was a laundry room with washing machines, drier and ironing facilities. Staff responsible for this area had been in post for three years and was fully aware of the precautions needed to prevent cross infection, including the use of protective clothing, gloves and the importance of hand washing. The staff member told us about the different temperatures used for washing clothes and washing sheets and bed linen separately and they were aware of Control of Substances Hazardous to Health (COSHH) guidelines and the need for safe storage. We saw that these products were stored separately in a lockable area. This ensured that people were safe from the risk of substances that may cause them harm.

However, we observed that medicine was administered using a metal spoon, the person administering medicines did not wear gloves.

We spoke with the chef for the home who told us that they had a five star food rating from the Food Standard Agency (FSA) in February 2015. The chef told us that the home had had a five star rating for the last ten years and they had completed training in November 2014 in a number of topics including, food safety, health and safety, COSHH, infection control, fire and first aid. We were shown certificates of this training.

We saw that colour coded chopping boards were used to avoid cross contamination of food. Staff were aware what board and knives they need to use for each food product. Meat was stored correctly at the bottom of the fridge. The equipment including the microwave and the cooker hood was clean. Systems were in place to monitor fridge/freezer temperatures and serving temperatures. We saw that cleaning schedules were in place for daily, weekly and monthly cleaning, however we did not see the completed sheets confirming that the cleaning had been undertaken. The chef had left for the day and the staff on duty were unable to provide this information.

People were put at risk of unsafe premises. Some of the home was unsafe and in need of maintenance. For example the small chain and nail used to restrict the windows in the first floor lounge were unsafe, the sash cord was broken on two of the windows which when opened fell back down. This put people at risk of harm. One window was painted shut and could not be used. In one person's room we found no window restrictors and there were none in the office window and window in the staff room. The staff room was not locked, so accessible to people who were mobile. This put people at risk of falling out of the window. Health and Safety Executive guidance states that 'where assessment identifies that people using care services are at risk from falling from windows or balconies at a height likely to cause harm, suitable precautions must be taken. Windows that are large enough to allow people to fall out should be restrained sufficiently to prevent such falls. The opening should be restricted to 100 mm or less. Window restrictors should only be able to be disengaged using a special tool or key'. The window restrictors at the home could easily be disengaged by hand. We identified this issue to the manager and area manager at the time of our inspection. Following our visit we were informed by the acting manager that the all window at the home had been fitted with restrictors on the 18 May 2015 and replaced with the correct type using a special tool or key. The acting manager told us that between the 11 May 2015 and 17 May the home had fitted temporary restrictors to windows where there were none and reinforced the ones in place on the day of our inspection.

We found a chest of drawers had handles missing in one person's room. In another bedroom we saw there were broken tiles behind the toilet. We reviewed the home's maintenance book from January 2015 to April 2015, this details maintenance works completed and when. We saw that none of the repairs seen on the day of our visit had been identified. We were told by the administrator that staff

Inadequate

Is the service safe?

report any repairs to her and this would be reported to the maintenance person used by the service. However a formal process was not in place to record when repairs had been completed. We informed the acting manager of our findings and she noted this down for action

We concluded that these were breaches of Regulation 12 of the Health and Social Care Act 208 (Regulated Activities) Regulation 2014.

We saw that the service recorded incidents and accidents. We reviewed the incident book and saw that there were a number of incidents involving one person against other people at the home. These incidents took place in January 2015 but had not been reported to the local authority and Commission. These incidents were notifiable as a condition of the provider's registration. There was no system for recording the outcome of incidents and learning following an incident. The acting manager informed the local authority in retrospect.

This is a breach of Regulation 18 of the (Registration) Regulations 2009 (Part 4)

We looked at personnel files of five staff. We saw that staff had been subject to the necessary checks to ensure they were safe to work with the people living at Acacia Lodge, including a criminal records check, proof of identity and address and verifying references from previous employers. We noted for one staff member their criminal records check had last been completed in January 2005.

Inadequate

Is the service effective?

Our findings

Staff did not receive adequate training to help them meet the needs of the people they cared for. We reviewed training records for two staff responsible for administering medicines. The acting manager told us that she was responsible for assessing the medicines competency of the senior staff. We noted that senior staff had medicines competency assessments which amounted to notes on file completed by the acting manager. In January 2015 the acting manager had recorded that a staff member felt that they needed more training in medicines, however none had taken place. Staff confirmed that they wanted more support and training in medicines and time to complete tasks. The only evidence of medicine training was a yearly one day medicines course. However, these records covered 2012 and 2013. Training certificates for 2014 medicines training could not be located by the acting manager. The community pharmacist who delivered training was contacted during our visit and asked to provide training certificates for 2014 as these were not available. Yearly refresher training with the community pharmacist is booked for June 2015. Staff also expressed a need for more training in areas such as, safeguarding, dementia and mental health, they told us that this would give them a better understanding of people's needs.

Staff files reviewed contained certificates for one day training for common induction in care as part of continuous development. However, we saw that this covered 20 subject areas, including risk assessment and care planning, medicine administration, 'Mental Health and Capacity Act' dementia awareness and support and health and safety, including first aid and infection control. This was part of refresher training completed yearly by staff. However, this training had been not been effective in ensuring staff had knowledge and understanding about the MCA, risk assessments and care planning and medicine administration. The acting manager told us that they had been approached by a company to provide National Vocational Qualification (NVQ) training to staff. We informed the acting manager that this training was no longer recognised as NVQ, this had been replaced with Qualification and Credit Framework (QCF).

We reviewed staff supervision records for 14 staff members and saw that staff had received supervision between January 2015 and April 2015. However, records also showed that prior to 2015 staff had not received supervision for 12 months or more. Staff had not received an appraisal and we saw no evidence that these had been completed for 2014. The acting manager told us and records showed that she had sent a letter to staff thanking them for attending an appraisal, however, we saw no other evidence that an appraisal had taken place. We spoke with the acting manager about this who told us that she had not used an appraisal form, but training and development was discussed. Staff confirmed that they had not received an appraisal. Regular planned staff supervisions are important as these provide a formal framework to reflect on practice and performance and can be used to identify any training needs or areas of development. We saw

staff had completed a comprehensive induction.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Management and staff demonstrated a lack of understanding in relation to Mental Capacity Act (MCA) 2005 Code of Practice and Deprivation of Liberty Safeguards (DoLS). Care records showed that people's ability to make a decision in everyday matters such as receiving personal care and nutritional or medication assistance had not been assessed within their care planning arrangements. For example, the provider did not have robust policies and procedures for obtaining people's consent to care that reflected current legislation and guidance, and followed by staff at all times. The principles of DoLS had not been fully considered for people living in the service. The service was a locked environment and key pads were used for the entrance to the building. The acting manager and provider was not aware of and had not taken appropriate steps in line with recent amendments in the DoLS legislation. With the exception of one, applications had not been made to appropriate professionals for assessment for people who lacked capacity and needed constant supervision or restrictions to keep them safe. The acting manager told us that they had been advised by a local authority not to submit all the DoLS applications all at once

We saw no evidence of mental capacity assessments or best interest meetings where people lack capacity, therefore unable to make decisions about their care. We found one person who was given covert medicines did not have a best interest decision to assess whether this was in

their best interest. Although bedrail assessments had been completed, we found two people did not have a mental capacity assessment completed to assess their capacity to consent to bedrails or evidence that a best interest decision involving family and healthcare professionals had occurred. One person had a health and safety risk assessment which stated, “Cot sides up” even though there is no MCA or best interest decision process to support this decision.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We used SOFI to observe lunchtime in the downstairs dining room. We saw that there was a white board in the dining room, this was used to write down the menu. However, we did not see a menu in another format, such as pictorial which would have been more accessible to people living at the home. Therefore some people may not be aware of the choices available to them. We observed that some people were given a choice fish or lamb, whereas others were not. The plate was placed in front of people without an explanation of what they were getting. One person who waited 20 minutes before getting his lunch had been given a meal he did not want twice before getting the lunch of his choice. People were given a choice of desert, including fruit salad. One person commented on the food, “It’s lovely, you get what you like.”

Inadequate

Is the service caring?

Our findings

People told us that they felt well looked after. One person said, "They look after us well here, very nice, I'm grateful for any help I can get. That [staff member] is very thoughtful and good." A relative told us, "The take good care of [relative]…..He is always clean and neat at Acacia and appears to enjoy his food…."

The acting manager and staff told us that they operated a key working system. This involved staff assigned to people. Part of their role as keyworker is to ensure that their room is kept tidy and people's belongings are where they are supposed to be everything about their care should be met. Relatives and friends were able to visit at any time, many came in the early evening and it was never seen by staff as inconvenient. This was confirmed by relatives.

We observed some good interactions between staff and people living at the home. Staff we spoke with knew how to ensure people maintained their dignity and respect. This included, ensuring the door was closed when providing personal care, giving people a choice, asking them what they want to wear. We saw that some staff approached people in a kind and caring manner, talking to people about their lunch and asking them if they wanted assistance. However, during lunch time we observed very little interaction between staff and people when they were assisting them with eating and drinking. We noted that on two occasions staff stood up whilst assisting people. We also observed a staff member talking in abrupt manner to one person who would not eat their lunch.

At our last inspection in May 2014 we found that the provider was in breach of the relating to records. We found records relating to people using the service were not accurate and up to date. Care plans and risk assessments were not updated following a change in the person's needs. People were not protected from the risk of unsafe or inappropriate care and treatment because of lack of accurate and proper information about them. At this inspection found that the service had not improved and there was a continued breach of Regulations relating to the accuracy of care records.

We reviewed care records for 11 people using the service. Each person had a care plan which had been reviewed. Care plans covered areas such as activities, daily living and relevant information such as gender preference for personal care. People's likes and dislikes were recorded in some care plans. However we found a number of gaps in care records reviewed. In one person's care plan we found two care plans in place, one reflective of the person's needs whilst the reviewed care plan incorrectly referred to the person as being mobile and able to manage their self-care. When in fact their needs had changed as they were no longer mobile and required more support with their personal care. The acting manager confirmed that this person's was receiving end of life care and that their health had deteriorated. She told us that the correct care plan should state that the person can no longer mobilise. The care plan had not been updated to reflect the person's end of life needs or an end of life care plan in place We saw that the district nurse had visited the person and provided information on end of life care. This person also had a Do Not Attempt Resuscitation (DNAR) form in place and a written statement of her wishes. Although this person had mental health care plan, we did not see any evidence that their capacity had been assessed to decide whether they were able to make this decision or that this was in their best interest. Therefore this person was put at risk of receiving inappropriate care that did not meet their needs.

In another care plan we saw that this was not written in a person centred way. For example, in the night report for this person staff had recorded, "slept well, very drenched," This was not appropriate and did not provide details of what had happen or action taken. For the same person the health and safety assessment stated that the person must not be left unattended and must be assisted at all times, however the review stated that the person mobilises independently. This information is contradictory and is unclear, therefore a risk of staff not providing appropriate care.

We reviewed MUST scores for six people and found five of the six MUST forms did not have people's height recorded to enable staff to reach the correct score to determine whether people were at risk of malnutrition. Staff did not follow MUST guidelines, therefore they had calculated the score without this important detail. For one person their weight had been recorded as 40.04kg with a height of 5ft 3 inches, which is an equivalent of 1.6 metres. Therefore this would calculate to a BMI of 15.6 and a MUST of two (high risk of malnutrition), however the person's care plan stated a BMI of 19 and a MUST of zero (low risk). For other five people we noted that their height had not been recorded on the MUST tool, we searched other documents for places

Is the service caring?

where this information would be, but could not locate this information. For one person the nutritional risk to this person from January to April 2015 was recorded as low, even though their height was not documented in their care plan, therefore staff were unable to determine MUST level to enable them to appropriately assess the risk. These inaccurate scores put people at risk of receiving care that was inappropriate and of not getting their nutritional needs met. The acting manager and owner agreed that staff required further training to understand the MUST tool. The acting manager said that they would review the MUST scores for each person and provide staff with additional training.

For another person their care plan had indicated that they were at risk of getting urinary tract infections (UTI). This had happened twice over a four week period on 17 March 2015 and 22 April 2015. However, we found this person did not have their fluid intake monitored. The incontinence care plan stated, 'incontinence able to take [person] to the toilet.' This did not contain information on how staff should support them and how to prevent the person from developing a UTI. This put the person at risk of contracting a UTI and therefore not receiving the care they needed. This person's care plan also made reference to an accident resulting in a bruised elbow, this was not recorded in daily records or the incident book.

In another person's care records we saw that they had an 'eating and drinking' care plan which had been reviewed. This stated that, "[person] eats a diabetic meal prepared by the chef." This did not include information about the type of diet, effects such as hypoglycaemia (low blood sugar levels) and hyperglycaemia (high blood sugar levels) and did not give staff guidance to ensure the person had their nutritional needs accurately met and the identified risks associated with their condition. However, the reviewed care plan had another person's name on it. The acting manager told us that this was an error and said that she would correct this immediately. This person's incontinent care plan did not state how the person should be supported. Therefore this person was put at risk of receiving care that was inappropriate and did not meet their needs.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We observed people freely moving around the home. Staff told us that activities took place at the home. This included bingo, playing cards, sing-alongs to the piano and reading. However, we observed very little activity taking place on the day of our visit and did not see an activities programme. We saw that two people went out with their relative on the day of our visit. We observed the activities coordinator giving a bingo session in the ground floor lounge. However, we saw that people were not responding and some had fallen asleep. During the inspection we noted that in two of the rooms there was a calendar which was showing April 2015 instead of the current month May 2015. Although not all relatives commented about the activities at the home, one relative said that they were concerned that there were no activities or stimulation.

People did not always receive personalised care that was responsive to their needs. For example, one person prescribed pain relieving medicine was not given this as prescribed. We saw that a doctor had visited this person in April 2015 and recorded in their care plan that the person was, "Still shouting, need to ensure [person] is not in pain for regular liquid Codeine script done." We asked staff where the pain relieving medicines were, but this had not been followed up by the home. This left the person untreated for 20 days, until the day of our visit on 11 May 2015. The acting manager was unaware of this, despite staff recording in the person's daily records on four separate occasions between April 2015 and May 2015, 'groaned all night', 'screaming repositioned,' 'screaming as usual' and 'screams a lot.' Therefore this person's individual needs were not met by the service.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of involvement from other healthcare professionals, such as the dietitian, district nurse, palliative care and mental health teams, including the memory service.

The service had a complaints policy which we saw was displayed in the main entrance when you enter the building. The provider was in the process of updating the complaints policy and procedure. We saw that the service also had a suggestion box, but this had not been used by visitors, although we saw that relatives had given thank you cards. Relatives told us that they knew what to do if they wanted to make a complaint about the service and felt they could approach the acting manager if they had any concerns. One relative told us, "I think my [relative] is well looked after here, [relative] is clean and tidy and I have no complaints."

Inadequate

Is the service well-led?

Our findings

There was a system for obtaining feedback from people and relatives. We saw that relatives commented positively about the service. Comments included, "[relative] feels [relative] belongs here and has good relations with the staff" and "Staff are very welcoming and friendly which is excellent." The provider kept a book with appreciation cards sent by relatives in April 2015. One relative said, "thank you all for the great care you gave my [relative]."

We received a statutory notification in September 2014 to inform us that the registered manager would be absent for a period of time. This stated that the expected length of absence would be one month, however, the registered manager was still absent at the time of our inspection, although they attended briefly on the second day of our inspection. The provider appointed another manager during this period who had since left the service. We were notified in November 2014 that the current acting manager was in post. The provider who attended during the inspection informed us that they had been off for some time due to health reasons and had just returned. This period of change had led to inconsistency in the way the service had been managed.

Staff told us that they felt supported by the manager. Monthly staff meetings were held and we saw minutes of meetings held in 2014 and 2015. Minutes of a meeting held in February 2015 showed that 13 staff attended, this addressed areas such as medicine control drugs audits to be done weekly, recording of referrals to the GP, people to be toileted regularly during the day to avoid pressure sores. This showed that the manager had acted on issues identified in February 2015.

We found significant shortfalls in the way the service was led.

Leadership was not proactive and systems for monitoring the quality of the service were not always effective. Audits undertaken in relation to infection control and the general environment had not been carried out routinely since December 2014. There were no audits to monitor the quality of care plans and risk assessments. The monitoring visits and audits failed to identify the issues found at this inspection. For example, monthly medicines audits completed from February 2015 and April 2015 failed to identify the issues found on the day of our visit and indicated 100% compliance for medicines. The acting manager confirmed there had been no identified or reported medication incidents in the time she had been in post. We requested the most recent community pharmacist audit completed in June 2014, the acting manager was unable to locate this and the pharmacy confirmed that they would reissue a copy. The acting home manager confirmed there had been no identified or reported medication incidents in the time she had been in post.

We saw that incidents were recorded in an accident book designed for reporting staff accidents. The manager was unable to demonstrate how they identified any trends and themes in incidents and accidents across the service and where improvements were needed in order to minimise risks of similar incidents happening again. The provider was failing to continuously assess the quality of

the service to drive improvement or identify where lapses had occurred.

Although policies and procedures were in place, we found a number of policies had not been reviewed since 2009 and 2012. Therefore the provider may not have the most up to date information on best practice. The provider told us that they were in the process of reviewing their policies and procedures and we were shown a folder of policies which had been reviewed. The provider told us that they were in the process of updating their policies and procedures and some of these had been implemented and were on their computer system. This included the medicines administration policy and supervision policy.

We concluded that this was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who use services were not protected against the risks of receiving care or treatment that was inappropriate.** **Regulation(1)(a)(b)(c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care and treatment of people was not provided with the consent of the relevant person. The provider did not act in accordance with the Mental Health Act 2005** **Regulation (1)(2)(3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The registered persons had not ensured that appropriate information was shared or transferred to other persons, working with such other persons, people using the service and other appropriate persons to ensure the health, safety and welfare of people.

Regulation 12 (2)(a)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse because the provider did not have effective systems and processes in place to effectively investigate any allegation of such abuse. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against risks associated with inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to check the quality of care provided. Regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered persons had not ensured that staff received training as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 18(2)(a).
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider failed to notify the Commission without delay of incidents which occurred whist service were being provided in the carrying on of regulated activities or the consequence of the carrying on of a regulated activity. Regulation 18 (1)(2)(e)