Care Quality Commission

Bramble Lodge Care Home Limited

Eastgate Manor

Inspection report

Mickley Square
Stocksfield
Northumberland
NE43 7LY
Tel: 01661 845 000
Website: N/A

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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

We inspected this service on 6, 9, 12, 25 and 26 November 2015. All visits were unannounced except the visits on the 9 and 26 November 2015. The service was last inspected in June 2014 when it was found to be meeting all of the regulations reviewed.

Eastgate Manor is a care home which provides accommodation and personal care for up to 44 older people, some of whom have dementia. There were 34 people living at the home on the first day of our inspection and one person in hospital.

The building was split over three floors. The basement floor accommodated people with residential care needs, the ground floor people with nursing care needs and the upper floor people with dementia care needs.

A newly appointed manager was in post who had started working for the service in early October 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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

Summary of findings

and associated Regulations about how the service is run. The new manager informed us that they were in the process of submitting their application to become registered with the CQC as soon as possible. They were supported by operations management and a compliance officer from the provider's compliance team during our inspection.

Staff told us that staffing levels had been increased within the last month and this had enabled them to meet people's needs more appropriately. Staffing levels appeared appropriate, however there was a reliance on agency usage and key staff posts were vacant. Some staff did not pass important information about people's care on to incoming staff members when shifts changed. They did not always follow up on concerns or issues that had been identified with people's care and therefore people's needs were not always met.

Most staff training was e-learning based and the manager and training manager could not be clear on the accuracy of all of the training figures they provided. We identified concerns with staff practices including their knowledge of safeguarding and medicines management. Although training records showed that staff had been trained in nutrition and hydration and dignity and respect, our findings suggested that staff did not always apply what they had learned. Nursing staff had not received clinical supervision, other than observations of how they administered medicines.

Staff did not follow systems that were in place to protect people from abuse or improper treatment. In addition, vulnerable adults were not always protected from altercations with other people who lived at the service, or some of the behaviours certain people displayed. Incidents were not always reported and measures were not put in place to prevent repeat events. A staff training matrix showed the majority of staff's training in safeguarding had 'expired'. We had not been notified of a number of safeguarding concerns in 2015. The submission of notifications is important to meet the requirements of the law and enable CQC to monitor any trends or concerns. The manager has submitted some of these notifications retrospectively.

Medicines management was inadequate. Some people's medicines went out of stock meaning they did not get the medication they required and this may lead to a worsening of their condition. Staff did not always sign medicine administration records and therefore we could not reconcile if people had received their medicines. An increase in one person's prescribed medicine had not been actioned by the service.

Staff did not always recognise risks that people were exposed to in their daily lives, or mitigate against any risks that were identified. This included environmental risks which we identified on the unit for people living with dementia, where dangerous items were accessible to them. Some people were at risk of falls and they had not always been supplied with equipment they needed to assist them with mobility.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. Applications had been made to the relevant authorising body to assess whether certain individuals qualified to be lawfully deprived of their liberty. However, some applications were only made during our inspection as a result of our enquiries. There was a lack of documented evidence to demonstrate that care and treatment was sought in line with the MCA. This meant that people's rights to make particular decisions had not been protected, and some decisions that had been made on people's behalf had not been taken in line with the 'best interest' framework of the MCA.

Staff engaged with people politely and appropriately but they did not always respect them and promote their dignity. They talked about certain individuals in front of other people and discussed their personal lives without regard for those people they were supporting. Staff did not take appropriate steps to support people to maintain and promote their own dignity.

The provider had an auditing system in place which included various audit tools looking at areas such as care plans, dining experiences, medicines management, health and safety matters, infection control and catering provision. Although the provider's auditing tools were successful in identifying failings within the service, there was a lack of governance and oversight from the senior leadership team to ensure that these failings were addressed. Many of the issues that we identified at this

Summary of findings

inspection had been highlighted through the providers own quality assurance systems, but they had not taken steps to rectify these issues once they had been identified.

We discovered serious shortfalls in the maintenance of records and were unable to locate certain documents relating to people's care and treatment and the management of the service. Staff and management were unable to locate certain records that we asked to see. Staff did not always record information about the care that they had delivered and about specific actions they had taken.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 relating to the notification of other incidents. We have taken enforcement action and will report on any further action once it is complete.

Due to the serious shortfalls in all aspects of the service, we wrote to the provider during our inspection to request an urgent action plan which stated what actions they would immediately take to improve. We visited the service again on 25 and 26 November 2015 and found that sufficient improvements had been made to ensure people's immediate health, safety and wellbeing at that time. We will continue to monitor the provider's progress against their action plan and will revisit the service to ensure that people's health, safety and wellbeing is protected and promoted.

People received care and treatment that was so poor, we have judged that the service was failing to meet every aspect of the CQC assessment framework and we have rated it as 'inadequate'. This has also meant that the service has been placed into special measures. Services in special measures are kept under review and where action is not taken to immediately remove the location from the provider's registration, we will inspect the service again within a maximum of six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If they do not, we will take action to prevent the provider from operating this service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

There were insufficient suitably qualified and experienced staff employed and deployed to meet people's needs. Staff were not always competent in their roles.

Some safeguarding incidents that had occurred in the home during 2015 had not been notified. Staff had not always reported physical altercations and inappropriate behaviours between people living at the home and therefore they had not protected vulnerable people from abuse or improper treatment.

Medicines management was inadequate and some people's medicines went out of stock.

Staff did not appropriately assess risks to people's health and welfare, in respect of their care and the environment in which they lived.

Is the service effective?

Inadequate 

The service was not effective.

Not all staff had the skills, knowledge and experience to provide care to meet the needs of the people who used the service.

The requirements of the Mental Capacity Act 2005 were not met.

People did not always receive a suitable diet or adequate amounts of fluids although some improvements in the quality of the food served was noted during our inspection.

Referrals to health and social care professionals were not always carried out in a timely manner to ensure people's needs were met.

Is the service caring?

Inadequate 

The service was not caring.

Overall staff displayed caring attitudes towards people, but people were not always respected and their dignity not always promoted.

Confidentiality was breached when staff talked about people in front of other people living at the home.

People and their representatives were not involved in the planning of their care.

Is the service responsive?

Inadequate 

The service was not responsive.

People did not receive personalised care that was responsive to their needs. Recording was extremely poor and important information about people's care did not get passed between staff when shifts changed, to ensure continuity of care.

Summary of findings

Meetings to obtain the opinions and feedback from people and their representatives had not taken place. Future meetings were being scheduled by the new manager.

We could not review complaints, as the complaints file could not be located.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of management oversight of care delivery and other aspects of the service and a lack of direction and guidance for staff.

Audits and checks had been carried out but suitable action had not been taken when concerns had been identified. There were serious shortfalls in the maintenance of records relating to people and the management of the service.

The provider had not always submitted notifications to us in line with their responsibilities and legal requirements.

Eastgate Manor

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 visited the home on 6, 9, 12, 25 and 26 November 2015. All visits were unannounced except the visits on 9 and 26 November 2015. The inspection team consisted of three inspectors a specialist advisor, with experience of providing nursing care to older people, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses or used this type of care service.

Prior to our inspection we received information of concern which we passed on to Northumberland adults safeguarding team and they duly investigated. The concerns related to staffing levels and people experiencing delays in the receipt of care. We took this information into account in the planning of our inspection.

We did not request a provider information return (PIR) from the provider due to the rescheduling of this inspection. A PIR is a form which asks the provider to give some key information about their service, how it is meeting the five domain areas of safe, effective, caring, responsive and well led and what future improvements they plan to make to the service. We checked our systems and reviewed notifications that the provider had sent us over the twelve months prior to our inspection. We contacted Northumberland safeguarding adult's team, Northumberland contracts team and Northumberland Clinical Commissioning Group (CCG) to gather feedback about the service.

We spoke with, or had written contact with, the nominated individual, a director of the provider's company, the regional operations manager, the operations manager for the service, the manager of the service, the compliance officer for the service, the provider's training manager, three nurses, two agency care workers, 13 care workers, two chefs and five relatives or friends who were visiting the home. We looked at 16 people's care records plus a range of records related to the operation of the service including staff recruitment and training files.

During our inspection we spoke with the community matron who worked into the home regularly and we remained in touch with Northumberland safeguarding, CCG and contracts teams throughout our inspection to share our findings and concerns. Following our inspection the Northumberland safeguarding team shared concerns expressed by GP's who regularly visited the home to see their patients.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received information of concern about staffing levels and some elements of care delivery. We referred this information on to Northumberland safeguarding adult's team who initiated investigations into some of the concerns that had been raised. We considered all of the information we had received when planning our inspection.

At our inspection we found serious failings in respect of the care and treatment that people received and concluded that people were not safe. Staff told us they have received training in safeguarding people from abuse or improper treatment; however we found that staff's knowledge varied about the different types of abuse that people could be exposed to. The provider's training matrix showed that sixty-two percent of the staff team's training in safeguarding had expired and needed to be refreshed. We discovered that a number of serious safeguarding incidents had occurred over the 12 months prior to our inspection which had not been reported to Northumberland safeguarding adults team for investigation, in line with safeguarding procedures and the provider's own safeguarding policy. Altercations and displays of inappropriate behaviour had taken place between people living at the home. Some people had skin tears and unexplained bruising. These instances had not always been appropriately documented or reported, both internally through the management systems within the home, or externally to the relevant professionals. This meant that investigations to establish the facts had not always taken place, and subsequently, people were not always protected against the possibility of such incidents occurring again.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Safeguarding people from abuse and improper treatment.

Northumberland local authority placed the service into 'organisational' safeguarding during our inspection and accepted a number of people into individual safeguarding procedures for investigation. This meant that the local authority was monitoring the whole home since there were concerns that some of the staff practices were putting vulnerable people at risk. CQC will monitor the outcome of the safeguarding investigations and the actions the provider takes to keep people safe.

Risks that people were exposed to in their daily lives had not always been assessed. Staff did not always recognise risk or take actions to mitigate against risks where they had been identified. For example, one person was at risk of developing chest complications and pneumonia yet following a recent stay in hospital no risk assessment had been developed to manage this need and keep them as safe as possible. Another person who was at high risk of falling had been identified as needing handrails in their bedroom to assist them with mobility three weeks ago. However, these were not in place and senior staff did not know that they were required. One person at risk of pressure damage had not been weighed for over two months. Their pressure relieving mattress controls had been set for a particular weight, but neither staff nor senior management could confirm whether this mattress was set correctly, as their actual weight was unknown. This person had pressure damage to their skin.

Staff told us that there was only one hoist on the nursing floor of the home. As ten out of 14 people on this floor required the use of a hoist to aid their mobility, we deemed there was an inadequate stock of equipment available for the number of people. Staff said that only having one hoist meant people often had to wait for long periods to have their needs met. Also, if the hoist was in use, and a person who needed hoisting required the toilet, they would have to wait. Staff said this had resulted in people being needlessly incontinent. This showed that in addition to the shortage of essential equipment, people's dignity was compromised.

We identified risks to people living on the unit for people living with dementia, in respect of their environment. Staff did not recognise the risks posed when they "propped" open the office door with a chair, despite clear signage telling staff to keep this office door locked at all times. Most significantly, on one occasion when this office door was propped open, we saw a large bag on the floor which contained used razor blades (without covers), discarded medication and toiletries. These items were all accessible to people on the unit, and could have potentially caused significant injury. We had to prompt staff to safely dispose of this bag and its contents.

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

Inadequate

Is the service safe?

Medicines were not managed safely. People did not always receive the medicines they required, when they required them, as in some cases stocks had not been maintained. The manager told us that they were experiencing issues with supplies from the local pharmacy and were in the process of addressing this. However, there was no management oversight to ensure that each individual had sufficient medicine supplies available at all times.

The provider had a medication policy and procedure in place that was not followed by staff. Where people regularly refused their medicines, or refused them for a period of three or more days, the policy clearly stated staff should contact the person's GP for advice and instruction. We found evidence that people had been refusing their medicines for many days at a time with no action taken. One person had refused their medicine to reduce the risks associated with fluid retention, 14 times in a 25 day period, and no contact had been made with their GP to discuss this matter and any actions that needed to be taken.

One person had been prescribed an increase in one of their medicines which had been overlooked by staff. The additional quantity prescribed on the person's medicine administration record (MARs), had been crossed through and recorded as a 'duplicate entry'. The prescribed increase in medication had not been administered for over two weeks. A number of people were prescribed "as required" medicines which are given only when needed, such as for pain relief. We found specific care plans for these types of medicines were not in place meaning there were no clear instructions for staff to follow as to when and how these medicines should be given.

The recording of the administration of medicines was incomplete with many gaps identified on people's MARs. This meant we could not reconcile if people had received their medicines. Where creams had been prescribed to be applied at set intervals, topical administration records to show when these creams had been applied were in use for some people, but not for others. Care staff told us they were supposed to sign whenever medicines had been given. However, where topical administration records were in place, they were not always completed by staff. There were no body maps records to inform staff of where to apply people's topical medicines. We relayed our concerns regarding medicines to the manager and senior operations staff during our inspection. They told us they had already identified concerns with staff practice related to medicines through internal auditing some months previously, and this would be addressed.

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

Accidents and incidents were not always reported or recorded appropriately. Prior to our inspection we had not always been notified when people sustained injuries. Altercations between people living together at the home had taken place, but these incidents had not been recorded in line with policies and procedures. Other people had sustained minor injuries such as skin tears during the delivery of personal care and some had presented with unexplained bruising. There was no evidence that investigations had taken place to attempt to establish the reasons for these injuries. Where accidents and incidents had been recorded, there was not always enough information about the circumstances which had led to the event. There was a lack of detail around the event itself and the outcome for any injured parties. Accident and incident auditing had taken place up to March 2015 but not after this date. This meant that patterns and trends were not being monitored to promote learning and to put measures in place to prevent repeat occurrences. We identified several accidents and incidents that had not been reported to the relevant bodies, including the local authority safeguarding team and ourselves, so that further investigation could take place. This meant the provider was not keeping people safe.

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

We looked at the concerns that had been reported to us prior to our inspection in respect of staffing levels. The manager told us that since she had commenced in post in October 2015, the provider had increased staffing levels. We saw there were enough numbers of staff on duty on each of the days that we inspected, to meet people's needs. However, there were a number of permanent staff vacancies in key areas and agency staff usage was high in order to cover gaps. A clinical lead/deputy manager post was vacant initially, but a member of staff had been recruited to this position by the last day that we visited the

Inadequate

Is the service safe?

service. Nursing vacancies existed on the night shift and some staff were working their notice. These included nurses, care workers and catering staff. The manager told us that once these staff had left, there would be no permanent nursing staff employed to work the night shift, leaving a nursing vacancy seven days a week on nights. In addition, there would be nursing vacancies on the day shift. Overall, there were not enough staff employed in key areas with the correct competencies and skills to ensure people received a consistent service. Senior management told us they were working hard to attract experienced competent staff to the home and they were actively reviewing their recruitment activity. We noted that during our inspection there were a number of advertisements for vacant posts at the home, which the manager was in the process of recruiting to.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Staffing.

Staff recruitment procedures were thorough and appropriate checks had been carried out before staff started working at the home, including obtaining references from previous employers, DBS checks and checking identity.

Safety checks around the building were carried out regularly as was routine maintenance. Records showed that legionella testing of the water supplies was carried out and checks to ensure that utility supplies within the building were safe. There had been a recent problem with the functioning of the lift and this reoccurred during our inspection but was addressed promptly. Damp had emerged in one person's bedroom on the basement floor of the building and they had been temporarily relocated whilst maintenance repairs and redecoration were carried out to address this problem.

People told us they felt safe living at the home. One person said, "I feel really safe here." Another person told us, "There is someone (staff) about all night and they will look in on you to see how you are." We considered that although all of the people we spoke with told us they felt safe, the findings of our inspection indicated that they were not.

Inadequate

Is the service effective?

Our findings

We reviewed staff training files and gathered evidence which highlighted concerns around staff competencies in respect of how they applied their knowledge to their roles. Most of the training staff received in key areas such as moving and handling, was e-learning based and there was no evidence of how individual staff member's understanding and knowledge had been assessed. For example, one incident form referenced that a staff member had injured their back during a moving and handling procedure. However, there was no evidence of any action taken following the incident to address this, or to assess the staff member's competency in this area.

Staff displayed that they had knowledge in key areas such as safeguarding and dementia care. However, our findings suggested they did not always apply this knowledge in practice. For instance, safeguarding matters were not recognised as such and not always reported to management when they occurred. Nutritional training was not applied as people were not always appropriately supported when at risk of malnutrition. We saw that at times staff used distraction techniques when supporting people with dementia care needs who had become emotional or distressed, however, this approach was not consistently applied. Care worker records showed that they had received supervisions regularly and appraisals annually. Nursing staff had received regular supervisions and appraisal, but observational competency assessments of their clinical practice had not taken place, other than in medication administration. One nurse told us they lacked the confidence and competency to deliver a particular nursing procedure, stating that they had not had the appropriate training. We fed this back to the operations manager who said that this would be addressed.

Communication amongst the staff team and externally with healthcare professionals was poor. We identified that important information about people's care and treatment was not being transferred between changing staff teams. Where information was written on handover sheets, matters were not always followed up. There was a lack of accountability and senior care staff did not always carry out their responsibilities to action certain tasks and follow up ongoing issues. This resulted in people not getting the support, care and treatment that they needed. For instance, information about one person's changing care needs had not been passed over to the oncoming senior care worker, as it had not been verbally relayed in person or written on the handover sheets. One member of staff commented, "Communication is lacking. There are so many different people coming and going staff wise, we don't know who knows what."

External healthcare professionals supporting people living at the home commented there were times when staff on duty were not aware of why they had been called to visit a person. In addition the staff were not knowledgeable about the concerns that had been raised. Prior to our inspection the manager had set up a communication book for staff on the residential unit and dementia care unit to write down any questions they needed to ask a visiting healthcare professional. We found this book had not been used by staff who had bypassed this new system. The manager and operations manager told us they had concerns about the competencies and skill sets of some staff working at the home.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Staffing.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' and it also ensures that unlawful restrictions are not placed on people in care homes and hospitals. The manager told us that no-one currently living at the home had a granted DoLS authorisation in place, but that applications had been made to the local authority safeguarding team for assessment. We saw documentation in some people's care records which supported this. Following our inspection we learned that the provider made nine further DoLS applications for individuals who were deemed to be lacking in capacity and who were potentially being deprived of their liberty. The need for these nine applications to be submitted had not been identified prior to our inspection.

We found the provider had not consistently applied the MCA. Whilst we saw best interest decisions had been made for some people about the decision to reside at Eastgate Manor, this was not the case for everyone who lacked the

capacity to make this decision for themselves. We found examples where treatment options had been decided by the service without consultation with people's care managers or other relevant healthcare professionals. For instance, staff told us that one person had a skin condition which their family member did not want investigated and so it had not been pursued. A multi-disciplinary best interest decision had not been taken about this decision to not seek treatment. There were other examples where best interest decisions should have been taken but had not. These included a situation where safeguarding concerns had not been explored regarding one person's safety when they were taken into the community by a friend, and another person (with limited capacity) refusing their medication, leading to a worsening of their condition. Bed safety rails had been attached to one person's bed but there was no evidence of a mental capacity assessment having been done in respect of this, or a best interest decision having been taken to ensure this was the least restrictive option.

There was limited evidence in people's care records that people or their relatives, where they were unable to sign, had consented to the care and treatment that was planned. People with capacity told us they were not aware that a care plan existed about them and their needs and they had not seen it.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Need for Consent.

We found that people's nutritional and hydration needs were not being met. A number of people had lost weight and had been identified as at high risk of malnutrition. However, it was not always clear from people's care records what had been done to combat people's weight loss. Some people had been prescribed fortified drinks on prescription and we saw that these were administered. However, other people had been identified as needing a fortified diet but there a lack of monitoring of their dietary intake, to ensure they consumed fortified foods. The chef told us that nobody in the home was on a specialised or fortified diet to their knowledge. There was some evidence that people had been referred to dieticians for further advice and input into their care, but referrals had not been followed up when no response was received.

People were not weighed in line with risk assessments that had been created about their care in order to reduce the risk of weight loss and intervene where necessary. One person had suffered a significant weight loss in a short period of time, but this was not identified by staff, as they had not weighed this person at the regular intervals that had been set during care planning.

Food choices were limited. The chef showed us a handwritten two week menu that they had drafted which showed a limited variety of wholesome and healthy foods on offer. We saw that two main meal choices were offered at lunch, but the only difference between these two choices was that a different type of meat or fish was served with the same accompanying vegetables or chips. One member of staff said, "The food worries me. They (people) don't get home cooked food enough. They (people) don't get much for supper. Sandwiches made for tea are given again for supper. Sometimes we go down and get cereal for people." People told us that the quality of the food was "alright" and "ok". We spent time with people whilst they were eating lunch and saw that some people returned their food uneaten. People were not offered a choice of cold drinks with one member of staff commenting, "Everyone likes orange (juice) on this floor – that's what they always have, orange." Dessert was either tinned fruit and ice cream, or just ice cream or tinned fruit on its own. The manager told us they had recognised the food standards within the service needed to improve and they planned to address this as soon as practicable.

Staff were aware of people who needed their foods thickened to avoid choking and we saw that they received their fluids this way. Some people were on food and fluid monitoring charts although these were not always completed. Where they were, we observed staff completing these from memory, up to an hour after people had finished their meals. Staff asked each other how much individual people had eaten and drank, and then completed these records retrospectively. Some food and fluid charts showed no entries from late afternoon one day until 8.00am the following morning. Amounts of fluids consumed were not always totalled and there was no established amount in people's nutritional care plans to guide staff on what people's minimum food and fluid intakes should be and what action to take if this was not achieved. There was a risk that people would not receive adequate nutrition and hydration to promote their health and wellbeing. Due to inadequate recording and analysis, shortfalls in nutrition had gone unnoticed.

Inadequate

Is the service effective?

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Meeting nutritional and hydration needs.

People received support to meet their general healthcare needs such as receiving regular check-ups of their eyes and their teeth. However, we identified serious concerns regarding the timeliness of medical interventions when people presented as unwell. One person had been admitted to hospital and when we looked at their care records we found they had lost a substantial amount of weight in a short period of time. This had not been referred to the person's GP. In addition, a urine sample that had previously been requested by their GP had not been obtained and therefore not tested. We identified two other cases where urine samples had not been obtained when requested. Another person was hospitalised during our inspection as they were struggling to breathe. A visiting healthcare professional had highlighted in the person's care records that they potentially had a chest complaint seven days before a GP was called, who diagnosed a chest infection and prescribed antibiotics.

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

By the end of our inspection, and in response to our findings and prompts, a number of referrals had been made to health and social care professionals; however, we found these were not always documented and it was difficult to corroborate what action had been taken in individual cases.

Inadequate

Is the service caring?

Our findings

Some staff were more task orientated than others and did not engage with people as much whilst going about their work. There was little interaction between people who lived at the home and staff did not instigate this. In one of the lounge areas of the home we observed a member of staff engaged with an individual on a one to one basis for some time, but they did not include the other people who were present and watching on. People were asked how they were by staff, but often these interactions were limited.

We heard two staff talking in the communal lounge area in front of six people about the upcoming readmission of a person known to them. Whilst it was nice to hear of their enthusiasm to see this person again, they discussed details about this person's personality, behaviours and historic challenges they had experienced whilst caring for them previously. This was a breach of confidentiality.

We observed that a masseur visited the home and started massaging people's neck and shoulder areas in the communal lounge area of the unit for people living with dementia. However, they did not ask the receiving person if they wished to be massaged in the privacy of their own bedroom, and staff did not suggest that they did so. The masseur initiated personal conversation with the receiving person in this public area, where all persons present could hear. They played relaxing music during the delivery of their treatments, but this was competing with the television which some people were trying to watch and hear.

Staff talked about people living at the home without thought for their privacy and dignity. For example, care workers talked across the dining room about how much people had eaten and drank at that meal. We heard comments from staff said in front of people which included, "Are they all wanting fruit and ice cream", "X didn't want his dinner but he's had his fruit" and "X had eaten a bit of his fish and there are some peas left". When asked to assist a colleague one member of staff referred to people as a group rather than individuals saying, "When we have finished feeding these". Staff also discussed activities they were pursuing in their personal lives during the serving of meals.

Several safeguarding incidents had occurred at the home within the past year involving some inappropriate behaviours displayed by people living at the service. These safeguarding incidents had not always been appropriately reported meaning that people's dignity and personal space was not protected or promoted.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Dignity and respect.

There was a lack of evidence to demonstrate that people or their representatives were involved in people's care. One relative who had been coming to the home for a number of years told us that they only heard from management when the manager changed. Other visitors told us they were made to feel very welcome when they came to the home and they had good verbal communications with the manager. They told us they believed they would be kept advised about any developments and changes in the care of their relative or friend.

The new manager had scheduled meetings over the next few months for people and their relatives to attend if they wished, so that they could introduce themselves, share information about the service and collate their views. Following our inspection, plans were made for a multi-disciplinary team to inform people and their relatives about the concerns that had been identified during our inspection.

People and their relatives commented on the staff that provided care saying they were "helpful" and "very nice". One person said, "They (staff) help keep you clean and tidy." A visiting relative told us, "My wife gets on so well with the staff." We saw that people were well groomed and presented.

Some staff were caring and interacted with people appropriately spending time talking to them and enjoying conversations about past times. They led people by the hand and supported them gently when moving from the lounge to the dining area. Staff used localised terminology when engaging with people, such as calling then "hinney" (lady) and "pet", which people appeared comfortable with. One lady became unsettled and a member of staff immediately sat with her until she became calm.

Inadequate

Is the service responsive?

Our findings

We identified serious shortfalls in recording and records. People did not always have care plans and risk assessments in place and where they did, in most cases these lacked detail. This meant that pertinent information was not available to staff to ensure they delivered care appropriately and safely. For example, one person had a care plan in place related to particular behaviours they displayed, but this was not detailed enough and there was limited monitoring of their behaviours to identify any trends. Another person was at risk of chest infections and pneumonia but there was no specific care plan in place to instruct staff on how to support this person and mitigate the risks of them developing further chest complaints.

Some care plans did not provide critical information about individual's care, such as what setting pressure relieving mattresses should be set at to support people's skin integrity. Where people had been identified as being at risk of malnutrition there was no information in their nutrition based care plans about what their minimum fluid intake should be, and when and what interventions should take place if this was not reached. Staff working with people living with dementia told us that food and/or fluid recording was maintained for four people, but we saw from records that there were additional people who had lost weight in recent months whose dietary and fluid intakes were not being monitored.

Dietary and fluid intake information was recorded on a form entitled "Individual daily statements of health and wellbeing". Staff also recorded on this form information about personal care delivered to people including support with continence, washing, bathing and positional changes if necessary to prevent skin damage. Recording on "Individual health and wellbeing charts" was poor and there were gaps in information which meant that neither we, nor staff themselves, could be sure that people's needs were met.

Staff also used a communication book, handover sheets and a diary to record information related to people's care and related tasks that had, or needed to be carried out. Individual sheets were held within people's care records to record any visits from, and contact with, healthcare professionals involved in their care. Through discussion with staff and reviewing these records, we established that information was not always recorded when it should have been, and was sometimes in the wrong place, making it very difficult to find. As a result, staff were not always aware of all aspects of people's care and their current needs. We found information about people's care which staff confirmed they were unaware of and important information and medical instructions had been overlooked because of poor record-keeping. There was a risk that people could receive inconsistent or unsafe care and treatment.

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

This is also a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, entitled Good governance.

Activities within the home were provided by two activities coordinators. We saw people enjoyed making poppies for Remembrance Sunday during our visits early in the month of November. Activities boards throughout the home showed that a number of activities were scheduled to take place daily. One of the activities co-ordinators told us, "I would love to be able to take people out and about more, but it's down to staffing levels that we can't."

A complaints procedure was in place and we were aware of a file entitled "Complaints". However, when we asked to review the documentation within this file during subsequent visits to the home, the manager said this could not be located. This meant we could not review how the provider handled complaints or concerns and to establish what actions had been taken, if any, to address these.

Inadequate

Is the service well-led?

Our findings

The newly appointed manager was present on the majority of days that we inspected and assisted us with our enquiries. They were supported by operations, compliance and senior managerial staff from within the provider's organisational structure. The manager told us that she was in the process of applying to become the registered manager of the service with CQC.

We found a lack of oversight and governance of the service which had led to the serious concerns identified and referred to in this report. We fed back our findings of multiple concerns to a senior manager. Staff told us that there had been a lack of direction from previous managers and there had been a succession of managers who had worked at the home for short periods of time during the last three years.

Throughout our inspection we identified concerns relating to a lack of oversight and management. The manager had introduced a communication book on the first day that we inspected where staff could share concerns with the community matron who was supporting the home. However, we found that this was not being used by staff and the manager or operations manager were not aware of this until we pointed this out to them. Handover information was not always being followed up by senior staff and important updates about individuals and their care was not being passed from one shift to the next. We established that management were not aware of these shortfalls and were not checking that verbal or written handovers were adhered to.

The provider was not always able to answer our requests for information during our inspection. For example, a matrix to demonstrate the current position in respect of staff training in key areas was not available to us and this information had to be collated following our inspection. When we received this matrix it showed that only a small number of staff had completed safe handling of medicines training. We spoke with both the manager and training manager who confirmed that they were not yet sure of the exact figures and would need to check staff files individually to establish their training requirements, if any, for staff with medicines administering duties. This lack of oversight of training needs demonstrated a failing in governance systems and a lack of staff leadership.

The provider had an auditing system in place which included audit tools to look at care plans, dining experiences, medicines management, health and safety matters, infection control and catering provision. Some audits had action plans attached to them and others did not. Where issues had been identified, there was no evidence to show that these had been addressed, as the action plans were not signed or dated as completed. The manager had historic audits in an in-tray in her office, which she told us she was aware of, but she did not know if they had been reviewed by other members of staff prior to her starting in post.

We saw a medication audit from September 2015 had identified a number of shortfalls in medicines management and an action plan had been drafted and attached. However, this action plan had not been assigned to a member of staff, there was no information about when it would be completed, and there had been no evaluation by the manager or senior person in charge at the time. All of these sections within the action plan were blank. A care plan audit completed in August 2015 identified that there were, amongst other findings, staff signatures missing from care plans, dependency assessments not completed and weekly weights not documented. This poor practice in recording was still ongoing at the time of our inspection and there was no evidence to demonstrate that these matters had been addressed with staff.

Accident and incident auditing had stopped in March 2015 and we found a number of accidents and incidents were unfiled in an envelope in the manager's office. There was no evidence that accidents and incidents had been analysed after March 2015 to ascertain if remedial action was required to reduce the risk of these events occurring again.

Although the provider had auditing tools in place that were successful in identifying failings within the service, there was a lack of governance and oversight by senior management to ensure that these failings were addressed. Many of the issues that we identified at this inspection had been highlighted through the providers own quality assurance systems, but they had not taken action to rectify these issues once they had been identified.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Good Governance.

Inadequate

Is the service well-led?

There were serious shortfalls in the maintenance of records across all areas of the service. For example, people's care records lacked detail, accident and incident documents recording was poor and records about topical medicines administration and food and fluid intake were not completed accurately. There was a lack of documentary evidence that investigations into people's conditions had taken place where needed, as this information had not been recorded in the relevant areas of people's care plans, or other records. In addition, we could not always establish whether referrals to healthcare professionals had been made when necessary, due to a lack of accurate recording. More importantly, neither the manager nor senior management present during our inspection, could find, clarify or provide documentary evidence to show that particular issues we asked about had been addressed.

Records that we required access to were not always available. Records related to the management of the service were disorganised and the manager and operations staff were not always able to locate records promptly. In-trays contained information from incidents and audits undertaken months earlier which had not been securely stored or filed away.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Good Governance.

We found that the provider had not notified us of several incidents including safeguarding concerns, in 2015. The submission of notifications is required by law and enables us to monitor any trends or concerns and pursue any specific matters of concern with the provider.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 entitled, Notification of other incidents.

We used our regulatory powers to request an urgent action plan from the provider about what actions they planned to take to improve. When we visited the home on 25 and 26 November 2015 this was following receipt of the provider's action plan to assess what action had been taken. We found that sufficient improvements had been made to ensure people's immediate health, safety and wellbeing at that time. We will continue to monitor the provider's progress against their action plan and will revisit the service to ensure that people's health, safety and wellbeing is protected and promoted.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not always treated with respect and their dignity was not promoted. Regulation 10(1)

The enforcement action we took:
We are taking enforcement action and we will report on this when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider and staff employed at the service did not adhere to their legal responsibilities under the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)(5)

The enforcement action we took:
We are taking enforcement action and we will report on this when it is complete

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who used the service were not protected against the risks associated with unsafe care and treatment because staff did not appropriately assess or recognise risks and they did not mitigate against them. Medicines were not managed safely. Regulation 12 (1)(2)(a)(b)(c)(d)(f)(g)(i).

The enforcement action we took:
We are taking enforcement action and we will report on this when it is complete

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People who used the service were not safeguarded or protected from the risk of abuse or improper treatment. Regulation 13 (1)(2)(3)(5)(6)

The enforcement action we took:
We are taking enforcement action and we will report on this when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: the provider did not have appropriate arrangements in place for people to receive suitable nutrition and hydration. Regulation 14(1)(2)(a)(b)(4)(a)

The enforcement action we took:
We are taking enforcement action and we will report on this when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place. Records were not accurately maintained and governance of the service was inadequate. Regulation 17 (1)(2)(a)(b)(c)(d)(ii)(f)

The enforcement action we took:
We are taking enforcement action and we will report on this when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care because the provider failed to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed and deployed. Staff vacancies existed in key roles and some staff practice lacked competency. Regulation 18 (1)

The enforcement action we took:
We are taking enforcement action and we will report on this when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The provider had failed to notify the Commission of other incidents such as safeguarding incidents. Regulation 18 (1)(2).

The enforcement action we took:
We are taking enforcement action and we will report on this when it is complete.