Care Quality Commission

# Roseberry Care Centres (Darlington) Limited

# South Park Care Centre

## 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? | Requires improvement |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

This inspection took place on 27-28 May and 2-3 June 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

South Park Care Centre was last inspected by CQC on 18 May 2014 and was compliant.

South Park Care Centre provides care and accommodation for up to 67 elderly people with residential and nursing care needs. On the day of our inspection there were 35 people using the service.

The home did not have a registered manager in place. 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 and associated Regulations about how the service is run.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

# Summary of findings

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Improvements were needed in many areas where the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service however the deployment of staff within the ground floor nursing unit was not appropriate for people's needs and a there was an over reliance on agency staff.

Little oversight was given to people who wandered the corridors and staff we spoke with lacked knowledge about individual people who used the service.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Systems and processes were not established and operated effectively to prevent abuse of service users.

Medicines were not recorded, administered correctly, safely, or in a timely manner.

Staff training was not up to date and staff did not receive regular supervisions and appraisals, which meant that staff were not properly supported to provide care to people who used the service.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

At the time of our inspection visit, DoLS were in place for people who required them however DoLS notifications had not been submitted to CQC. Therefore the provider was not following the requirements in the DoLS.

Nursing staff took no part in organising and overseeing food and fluid intake and the nutritional and hydration needs of service users were not being met.

The first floor residential dementia unit was colourful and included appropriate stimulation for people with dementia. However, the ground floor dementia nursing unit was dark, lacked signage and stimulation and was difficult to navigate.

Staff were caring however some people were not treated with dignity and respect.

Care records on the nursing unit were not an accurate, complete and contemporaneous record in respect of each person who used the service and did not include a record of the care and treatment provided to the person.

Care plans were not followed, which meant that care and treatment was not provided in a safe way for people who used the service.

We saw that the home had a programme of activities in place for people who used the service.

The provider had a complaints policy and procedure in place and complaints were fully investigated.

The provider did not have a robust quality assurance system in place and did not gather information about the quality of their service from a variety of sources.

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

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

The deployment of staff within the ground floor nursing unit was not appropriate for people's needs and a there was an over reliance on agency staff.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Systems and processes were not established and operated effectively to prevent abuse of service users.

Medicines were not recorded, administered correctly, safely, or in a timely manner.

**Is the service effective?**

Inadequate

The service was not effective.

Staff training was not up to date and staff did not receive regular supervisions and appraisals.

The provider was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Nursing staff took no part in organising and overseeing food and fluid intake and the nutritional and hydration needs of service users were not being met.

The lighting and design of the ground floor nursing unit was not appropriate for people with dementia.

**Is the service caring?**

Requires improvement

The service was not caring.

Staff talked to people in a polite and respectful manner.

Some people were not treated with dignity and respect.

Care records on the nursing unit were not an accurate, complete and contemporaneous record in respect of each person who used the service.

**Is the service responsive?**

Inadequate

The service was not responsive.

Care plans were not followed, which meant that care and treatment was not provided in a safe way for people who used the service.

We saw that the home had a programme of activities in place for people who used the service.

# Summary of findings

| | |
|---|---|
| The provider had a complaints policy and procedure in place and complaints were fully investigated. | |
| **Is the service well-led?**<br>The service was not well led.<br>There was not a registered manager in post.<br>The provider did not have a robust quality assurance system in place however we saw improvements had been made since the new manager had started working at the home.<br>The provider did not gather information about the quality of their service from a variety of sources. | **Inadequate**  |

# South Park Care Centre

**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 27-28 May and 2-3 June 2015 and was unannounced. This meant the staff and provider did not know we would be visiting. Three Adult Social Care inspectors and a specialist advisor for nursing practice took part in this inspection.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding staff and district nurses. Concerns were raised regarding staffing, care planning and responsiveness.

For this inspection, the provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the manager about what was good about their service and any improvements they intended to make.

During our inspection we spoke with six people who used the service and two family members. We also spoke with the manager, interim manager, director of operations and regional operations manager at Roseberry Care Centres (Darlington) Limited, three members of nursing staff, seven care staff, two agency care staff, two domestic staff, one administrative staff and a visiting social worker.

We looked at the personal care or treatment records of 13 people who used the service and observed how people were being cared for. We also looked at the personnel files for eight members of staff.

Inadequate

# Is the service safe?

## Our findings

We found care and treatment was not provided in a safe way for people who used the service.

We looked at staff rotas and discussed staffing levels with the manager and the interim manager. We saw there had been an over reliance on agency staff, particularly nurses, at the home. The manager confirmed no summary or handover sheets were made available to agency staff in the nursing unit and care records were difficult to navigate. This meant it was difficult for new staff and agency staff to know and understand people's individual needs.

We saw that although there appeared to be sufficient numbers of staff on duty, the deployment of staff was an issue as on a number of occasions staff were not present in the corridors or when needed. We noted that for the majority of the time we spent in South Park Care Centre, little oversight was given to people who wandered the corridors and staff we spoke with lacked knowledge about individual people who used the service. We found sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to support people who used the service. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a copy of the provider's recruitment and selection policy, dated 11 May 2015, and looked at the recruitment records for eight members of staff. We saw that recruitment records demonstrated that due processes had been followed and appropriate checks had been undertaken before staff began working at the home, including a written reference from the staff member's previous employer. We saw that Disclosure and Barring Service (DBS) checks had been carried out. The DBS checks if people have been convicted of an offence or barred from working with vulnerable adults. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We looked at the 'Accidents reports' file and saw no accidents or incidents had been recorded in the file since 25 March 2015. However, we saw 30 incidents had been recorded in February and March 2015. We also saw in one person's care records that the person had fallen on 10 April 2015, which had resulted in "bruising on the person's face, grazes and a small cut". However, this was not recorded in the accidents reports file.

We looked at the 'SOVA' (safeguarding of vulnerable adults) file and saw records of safeguarding incidents. The file included copies of four alerts raised between 21 May 2015 and 29 May 2015 and a further alert raised on 27 March 2015. Each record included details of the incident, what action had been taken and who the alert had been raised by.

We observed a person with a diagnosis of Alzheimer's disease was shouting and was reported to be very "challenging" to staff. We were told by the nurse on duty that staff were being given conflicting advice on how to deal with the person. We looked at the person's care records and found conflicting information with regard to managing their behaviour. We saw a record of a formulation meeting held before the person's admission to South Park in an occupational therapy assessment dated 17 March 2013. This stated that a hoist and sling should only be used as a last resort due to the person's increasing agitation. However, we saw the person's care plan, written by a nurse at South Park Care Centre on 2 February 2015, stated that "Care staff will transfer [Name] using a full body hoist with a medium sling". We noted there was no up to date occupational therapy review to evidence this decision. This care plan was contradictory to the person's occupational therapy assessment and was potentially increasing the person's agitation.

On 28 May 2015, we observed four care staff were attempting to mobilise the same person in their bedroom and move them into a wheelchair. The person was struggling and was shouting. The four staff were trying to control the person and prevent them from hitting out through the use of hand holds and other physical restraint techniques. We witnessed the manager and the interim manager enter the person's bedroom to assist, resulting in the interim manager being punched in the back by the person.

We looked at another person's care records and saw that they had been involved in an altercation with another person who used the service on 1 May 2015 and had

sustained some marks to their chest and arms. The person's best interests document dated 27 October 2014 referred to the person as being assessed as requiring a "challenging behaviour unit."

We saw that the service's statement of purpose was brief and stated, "The service user's treatment program or care plan must take into account the total needs of the service user i.e. physical, psychological, emotional, social and spiritual." We saw that the service's 'Physical restraint' policy discussed proactive action regarding restraint and referenced staff following techniques as agreed and entered in any care records. None of the staff we spoke with had received any training around how to safely use hand holds, breakaway techniques or how to physically intervene when a person was posing risks to others. We found that none of the staff spoken with were aware of the dangers associated with physical intervention or that medicines and equipment such as lap straps were a form of physical intervention.

We found from our observations of practice, documentation and from discussions with staff, systems and processes were not established and operated effectively to prevent potential abuse of people who used the service. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw all medicines were stored in a designated and locked 'Medicine room'. The room was small but contained a range of storage cupboards and a refrigerator. The room temperature was maintained at an appropriate level and we saw evidence of daily temperature checks. The medicine room refrigerator was lockable and we saw the temperature was also monitored. We saw sample signatures of nurses administering medicines were in place however these were not up to date due to the turnover of staff.

We saw the medication administration records (MAR) sheets were in a poor condition as a large number of them were torn at the attachment and not held firmly in the binder, leading to them potentially being misplaced.

On 27 May 2015, we looked at MAR sheets and saw a person was prescribed Alendronic Acid 70mg once a week. The person's MAR sheet was clearly marked over a four week cycle with identified dates and times for the administration of Alendronic Acid. We noted that Alendronic Acid 70mg had been due for administration to the person at 7.00am on the morning of the 26 May 2015. This had not been recorded as administered. No entry had been made on the MAR to indicate the reason for non-administration. The nurse on day duty was asked to highlight this to the nurse on night duty to ensure it was administered. On 28 May 2015, We spoke with the nurse and reviewed the handover sheet, and it was admitted that she had forgotten to record the information in the handover sheet. However, on reviewing the MAR sheet it was noted that a retrospective signature had been made on the MAR sheet for the morning of 26 May 2015 and no reason had been given on the record for the retrospective signature. It is now unclear from the records as to which day the Alendronic Acid was given, however it is clear that the MAR sheet was signed retrospectively.

We saw from the MAR sheets that a person was prescribed Memantine on a gradual titration. Memantine is a medicine used for the treatment of Alzheimer's disease. It was noted on the 27 May 2015 that there was approximately 20ml less than expected in the stock bottle. The nurse we spoke with about this matter could not account for the discrepancy and we could not be certain whether this was as a result of over administration or spillage. We discussed this with the manager, who was already aware of this issue and was recording a safeguarding alert in respect of this on 27 May 2015.

We also saw from the MAR sheets that a person was prescribed Lorazepam 0.5mg tablets for agitation on an as required basis. It was noted from the MAR sheet that one 0.5mg tablet of Lorazepam had been administered in the four week cycle. The staff signature was indecipherable, and no reason for administration was recorded. On reviewing the number of Lorazepam tablets held for the individual person it was difficult to clearly ascertain how many should be included in the total count, as in addition to the blister pack we also found a bottle with three 0.5mg tablets dated August 2014, as well as a packet with three 1mg tablets dated September 2014. We discussed this with the nurse on duty and no clear account could be given for the additional surplus Lorazepam tablets.

At 11:35am on 27 March 2015 we observed that medicines, which were due to be given at 9:00am that morning, had been delayed so some people had received their medicines late and others had not received any at all. The manager

Inadequate

# Is the service safe?

confirmed that the morning medicines had been delayed because the administration process had been changed. We reviewed the medicines records for twelve people at the home who should have received regular medicines from staff over the previous four weeks. Records showed that some people had not received medicines prescribed for them for the treatment of, Alzheimer's disease, depression, heart disease, circulation disorder, angina, congestive heart failure, osteoporosis, kidney/liver disease and anxiety/ depression. One person did not receive any of their medicines for one entire day. In this person's MAR it was recorded that they were 'Asleep'. All of these people were reliant on the provider to administer their medicines because they lacked the capacity to safely do so themselves.

It was not clear from records how many people who used the service were receiving covert medicine. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. We found a record that one person was in receipt of covert medicine as they were on a 'Covert medication pathway' however this document was written at the person's previous care home and not at South Park Care Centre. Discussions with nursing staff did not provide any clarity as to who was in receipt of covert medicines.

This demonstrated that the provider had failed to protect people who used the service against the risks associated with the improper and unsafe management of medicines. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that entry to the premises was via a locked door and all visitors were required to sign in. We looked in people's bedrooms and windows we saw were fitted with restrictors however some wardrobes were not secured to walls and had boxes and other items placed on top of them. This presented a potential health and safety risk to people who used the service, staff and visitors, which we brought to the attention of the manager and interim manager.

We saw hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

Portable Appliance Testing (PAT), electrical installation, gas servicing and lift and equipment servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, fire drills were carried out monthly and fire detection systems, emergency lighting, fire doors and fire fighting equipment were checked regularly and were up to date.

The service had an emergency and contingency plan and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service however we found the PEEPs for two of the people were not in the emergency evacuation folder. We found a further 12 PEEPs were incorrect as people had been moved to other rooms on the other floor and although the room numbers had been crossed out and replaced with the new ones, other information such as location of equipment and distance to travel had not been changed. We brought this to the attention of the manager and interim manager who agreed to update the PEEPs as soon as possible.

Inadequate

# Is the service effective?

## Our findings

People who lived at South Park Care Centre did not receive effective care and support.

We examined staff training records. These showed that the majority of staff had not received any form of training until March 2015 and many courses included in the training programme had still not been completed, such as infection control, pressure area care, care planning and food hygiene. We also saw the catering staff had not completed food hygiene level two courses. Staff we spoke with also displayed a lack of understanding of mental capacity and deprivation of liberty safeguards (DoLS) when questioned.

We discussed staff supervisions and appraisals with the manager and regional operations manager. The regional operations manager confirmed they were unable to find staff's historic supervision and appraisal records so had started the process again in May 2015.

We found staff did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records for a person and saw a letter from a Speech and Language Therapist (SALT) dated 20 April 2015. This advised that the person was to continue with a puree diet and described the food texture as, "Does not require any chewing. A thick, smooth, uniform consistency. Sieving may be required. Can be eaten with a fork or spoon. Holds its shape on a plate and can be moulded." Food examples were listed as, "Mousse, smooth fromage frais, porridge." We looked at the person's 'Puree diet' care plan, which stated, "[Name] was seen by the SALT due to holding food in his mouth leading to a risk of choking" and "[Name] is on a puree diet with no lumps in it". Daily records did not support the SALTs advice and we saw evidence that inappropriate food had been given to the person, for example corned beef.

Corned beef does not constitute a puree as described in the 'County Durham and Darlington NHS Foundation Trust' definition of 'Puree' which states, "Food has been pureed or has a puree texture. It does not require chewing. It is smooth throughout with no 'bits' (lumps, fibres, bits of shell, skin, bits of husk, particles of gristle/bone etc). It may need to be sieved. The 'Speech and language therapy swallowing guidelines' describes high risk foods as, "Dry/ stringy meat." We discussed this with the manager and the interim manager who agreed that this practice was unsafe and a safeguarding referral was made.

We looked at the 'Nutrition' care plan for a person, which stated the aim of the care was, "To prevent malnutrition and dehydration." We looked at the risk assessment record for the person, which stated, "All staff attending [Name] must be aware of risk of malnutrition and dehydration if insufficient intake ingested. Fortified diet and fluid is promoted." We looked at the person's 'Fluid balance charts' and saw that the person was recorded as not receiving any fluids between 5.00pm on 25 May 2015 and 10.00am on 26 May 2015. This length of time between the person receiving fluids increased the possibility of dehydration. We raised this with the manager who could not confirm if the person had received fluids.

We checked fluid intakes regularly throughout the day and saw that although people received fluids no system was in place to ensure this was guaranteed for people who remained in their room. We saw that staff filled in fluid balance charts when they remembered rather that when fluid was given, which could mean people had not received what was stated. We saw that no information was provided in care records about what amount of fluid people needed to remain adequately hydrated. On 1 June 2015 staff had provided 900mls of fluid for one person and when this was discussed with staff they could not say whether this was the recommended amount or what concerns there would be if people had insufficient fluids.

We saw that nursing staff took no part in organising and overseeing food and fluid intake. We were told by one nurse that a person who used the service was receiving a limited diet that day because they had loose stools so staff were offering dry toast. This person's food chart indicated they had received the full lunch, which was a cooked meal of casserole, mash and vegetables. We confirmed with the care staff that the person had been given the full meal and not toast. The care staff we spoke with were unaware of the nurse's instruction to only give the person toast.

We found the nutritional and hydration needs of service users were not being met. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We saw a copy of the provider's Deprivation of Liberty policy, which was revised on 2 February 2015, and described the responsibilities of senior and other staff with regard to DoLS, the procedures to follow and involvement of other agencies.

We checked the Deprivation of Liberty Safeguards (DoLS) records and saw DoLS had been authorised for 29 of the people who lived at South Park Care Centre. A further two were recorded as "to be confirmed." We discussed these authorisations with the local authority safeguarding team who confirmed the correct processes had been followed. However, Care Quality Commission records showed that only two statutory notifications had been submitted, on 24 June 2015 and 23 February 2015, for these 29 authorisations. This meant the provider was not following the requirements in the DoLS as they failed to notify CQC when DoLS were authorised. We discussed DoLS with the manager and the regional operations manager and the manager agreed to submit the outstanding DoLS notifications to CQC within two weeks.

We saw evidence in care records of mental capacity assessments being carried out and saw 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms which meant if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). The DNACPR forms we saw were up to date and showed the person who used the service, and family members, had been involved in the decision making process.

Care records we looked at contained evidence of visits from external specialists including social workers, GP, chiropodist and community nursing teams.

The first floor residential dementia unit was colourful and included appropriate stimulation for people with dementia. This included photographs of famous movie stars and displays on the walls such as a market place, flowers and a library. The first floor accommodation also had good natural and artificial light. However, the ground floor dementia nursing unit was dark, lacked signage and stimulation and was extremely difficult to navigate. Staff who had worked at the home for some time, agency staff and the inspection team found it difficult to find their way around. Although toilets and bathroom doors were clearly marked, the uniform colour scheme and no points of difference across the unit compounded this difficulty. The lighting on the ground floor was below recommended levels and meant that it constantly appeared to be dusk and it was difficult for people to see any obstructions or fall risks. We found the premises being used by the provider was not suitable for the purpose for which they were being used. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

# Is the service caring?

## Our findings

People who used the service, and family members, were complimentary about the standard of care at South Park Care Centre. They told us, "The standard of care is very good", "Things are getting better" and the staff were "All very nice".

On both the residential and nursing units, we saw staff talking to people in a polite and respectful manner and we saw evidence of very friendly exchanges between staff and people who used the service, all on first name terms. We saw staff making the effort to talk with people by bending down, squatting on the floor or sitting beside people so they could talk with them at the same level.

We observed lunch on the nursing unit. A number of people who used the service required assistance and we saw people were supported by staff in a calm and unhurried manner.

We observed lunch on the residential unit and saw staff encouraging people to go to the dining table. One person wanted to stay in her armchair in the lounge so staff brought her a small table to use. People were asked if they wanted to wear an apron to protect their clothes and consent was obtained before placing aprons on people. We saw there was a calm and relaxed environment and staff spoke with people in a patient and easy to understand tone of voice. Drinks were regularly offered and topped up and a choice of meal was offered. Friendly exchanges took place between staff and people who used the service. For example, one member of staff told a person, "If you don't eat some you have to go and wash the pots". This made people laugh. People were assisted if required however independence was promoted as people were encouraged to feed themselves.

We spoke with a visiting social worker on the residential unit who told she had no issues and was praising of the staff. She told us the senior care staff member "Gets things done" and was "Reliable".

We saw people's dignity and privacy was not always respected on the nursing unit. We observed a person take off their trousers in their bedroom and saw they had soiled their clothing. We went to the ground floor lounge and informed a member of the care staff who went into the person's bedroom and closed the door. Several minutes later we observed the person walking up the corridor from their bedroom with no lower body clothing on. There were no staff present in the corridors so we brought this to the attention of the director of operations, who called staff to assist.

On another occasion, we observed the same person leave another person's bedroom, the bedroom door was left open. It was not possible to say how long the person had been in the other person's bedroom but on entering the bedroom we saw the person was slumped forward in their chair, which was visible from the corridor outside. The bedroom window was open and leaves had blown in and were blowing around the bedroom floor. The person was drooling onto a rug on their knee. We found a member of the care staff in the dining room, who when informed went into the bedroom to see to the person's needs.

We found that people who used the service were not always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care records for people on the residential unit and saw care plans in place for mobility/falls, nutrition, continence, pressure areas, personal hygiene, communication, emotional and mental well being, social stimulation, sleeping, end of life and medication. We saw each care record included a 'Service user description sheet', which included the person's preferred name, date of birth, a photograph of the person, who the person's key worker was and details of the person's next of kin and GP.

The care plans on the residential unit contained evidence that people had been involved in writing their plan and their wishes were taken into consideration. For example, we saw details of people's backgrounds, their likes and dislikes and their care and support needs. There was also evidence of discussions with the person about their care, for example, what the person could do for themselves, what they required assistance with, things they enjoyed doing, what they preferred to eat and their religious and spiritual beliefs.

We also saw evidence on the residential unit that family members were involved in people's care and were kept up to date. For example, "Contacted family to inform of GP visit today and what the GP is going to prescribe" and "Left a message to say that her new glasses arrived today".

Requires improvement

# Is the service caring?

However, we noted that the care documentation in the nursing unit varied in quality and content and was an untidy mixture of assessments and care records which were difficult to work through due to the random filing methods. Some documents (particularly those from the previous location some of the people who used the service were from) were poor, both in completion and quality of information. We found the care plans were not personalised and whilst they did contain a 'This is me' document, the majority were either blank or contained very little information.

These records were not an accurate, complete and contemporaneous record in respect of each person who used the service and did not include a record of the care and treatment provided to the person of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service responsive?

## Our findings

The service was not responsive. We saw that care records were not regularly reviewed and evaluated on the nursing unit.

We looked at care plan records in relation to skin pressure care for one person, which stated the person was not to be placed on their left side in bed as they will tend to push themselves further over, causing their face to be covered in their pillow, posing risk of suffocation. We looked at the positional charts records for this person and saw on a number of occasions that staff had recorded the person's position as being "LT". We confirmed with staff this was the position code for Left side. We found that the act of positioning the person on their left side was contrary to the care plan and had the potential to place the person at risk of suffocation. We discussed this with the manager and the interim manager who agreed that staff were not adhering to the care plan and they could not be assured that the person's pressure care had been maintained and their safety carried out in conjunction with their care plan.

We looked at the 'Skin damage/pressure sore' risk assessment for the same person, which stated the person "needs checking regularly to maintain general safety and skin integrity." We examined the person's intentional rounding charts records at 3.15pm and saw that the records for 1.00pm, 2.00pm and 3.00pm were blank. Intentional rounding is a structured approach whereby staff conduct checks on people at set times to assess and manage their fundamental care needs. We examined the records again at 3.35pm and saw all three had been retrospectively completed. We found that despite this retrospective completion of the record that the intentional rounding charts for 28 May 2015 showed that there had been a gap in checks of the person of at least three hours. We found that staff, by retrospectively completing records, were failing to ensure risks associated with either lack of movement or records not being completed in a timely and accurate manner were mitigated.

We looked at the care plan records in relation to skin pressure care for the same person, which stated the person "is unable to reposition whilst in bed or sitting up in their specialized recliner chair" and "[Name] is unable to assist carers to maintain a good level of pressure area care" and "[Name] requires assistance in all aspects of their care". We examined the person's rounding charts records which recorded the positional changes and saw that these records stated that staff had recorded the person's position as being 'Self-Positioning'. This did not reflect the information in the person's care plan. We discussed this with the manager and the interim manager who agreed that the records were contradictory to the care plan and they could not therefore ascertain that the person's pressure care needs had been carried out safely and in conjunction with their care plan.

We looked at a persons' 'diabetes' care plan, which stated "[Name] is a type 1 diabetic that is injection controlled" and "The nurse is to liaise with diabetic team if [Name]'s blood sugar monitoring becomes out of range. Normal blood sugar levels range 4-7 mmols". We examined the person's 'Insulin administration record of administration', which was kept with the medication administration records (MAR) and saw the person's blood glucose levels fluctuated significantly and regularly exceeded 20 mmol/l (millimoles per litre). The fluctuating range was of concern, and the care plan did not appear to be followed in terms of highlighting the issues to the diabetic team when the levels were out of range. We looked at the staff 'Daily Handover Sheet' for 22 May 2015, which stated for the person "Stable BM's [blood sugars] Insulin as prescribed. Settled and content, no concerns" however the Insulin administration record of administration for 22 May 2015 recorded a level of 25.5. We also looked at the staff 'Daily Handover Sheet' for 26 May 2015, which stated for the person "BM's stable" however the Insulin administration record of administration for 26 May 2015 recorded levels of 5.7 at 9.00am and 19.2 at 5.00pm.

We saw that the person's diabetes care plan evaluation stated on 11 May 2015 that "BM's have been high so [Name] has been referred to the diabetic nurse." However, it was not possible to elicit from the care records whether the referral had been made, who had made it and what degree of urgency had been emphasised. We discussed this with the manager and the interim manager who said they could not find any written evidence of a referral to the diabetic nurse or any involvement from the person's GP. The interim manager agreed the care plan had not been properly reviewed since January 2015, despite being reviewed in March, April and May 2015 by nursing staff. The manager told us that she had "Been in at 7.30am every morning and sat through handovers and the person's diabetes hasn't been mentioned once." We spoke with the diabetic liaison

Inadequate

# Is the service responsive?

nurse at the local GP practice who confirmed there was no record of a referral for this person until 27 May 2015, the date we brought this to the attention of the manager and interim manager.

This meant the provider had failed to take proper steps to ensure that care and treatment was not provided in a safe way for people who used the service. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed care staff moving people in several rooms in the nursing area of the home. This involved movement to and from wheelchairs. From these observations, we saw all movements were undertaken in a safe manner and clear explanations were given.

We saw people taking part in activities on both floors of the home, such as painting and singing. We saw an activities planner on the main door, which included floor games, arts and crafts, cake decorating, bingo, movie club and musicals. We also saw a coffee morning had taken place on 29 May 2015.

We saw a copy of the provider's complaints policy, dated 7 May 2015, which described the provider's complaints process. We also saw a copy of the complaints procedure was on the notice board on each floor and included details of who to make a complaint to and who to contact if the person was not satisfied with how their complaint was handled. We saw the complaints file, which included a complaints register. This recorded the date a complaint was received, who received the complaint, the type of complaint, brief details of action taken, the date the complaint was resolved and the manager's signature. We saw copies of complaints, including emails and letters to complainants, statements provided by members of staff and details of investigations carried out. Family members we spoke with were aware of the complaints process. One family member we spoke with had recently made a complaint and told us she was happy with the action taken. This meant that comments and complaints were listened to and acted on effectively.

Inadequate

# Is the service well-led?

## Our findings

At the time of our inspection visit, the home did not have a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The home had a new manager in post, who told us she was going to apply to register as soon as possible.

We looked at audit records and found little evidence of regular audits prior to May 2015. We examined the 'Care plan audit file' and found the last care plan audit recorded on the cover sheet was on 25 January 2015. However, copies of audits were in the file for 17 February 2015 and 13 May 2015. There was no evidence of any care plan audits carried out between these dates.

We looked at the 'Medication audits file' and saw audits carried out on 6 March 2015 and 8 May 2015 were recorded as "Fail". The guidance provided in the file stated, "Should any care home score less than 90% then this part of the audit has been failed and an overall fail will be recorded for the full audit. Weekly medication audits must be conducted until this issue has been resolved." We saw no evidence of weekly medication audits in the file.

We also looked at the 'Internal audits file' and found 'Monthly catering audits' had been completed on 5 January 2015 and 18 March 2015. There were no records of any other audits being carried out prior to May 2015.

We spoke with the manager and the regional operations manager about the processes that the home had for assessing and monitoring the quality of the service provided to people residing there. They told us that this was an area that they had recognised they needed to develop but was "work in progress" and they "had to start again."

This meant that the provider did not gather information about the quality of their service from a variety of sources. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw improvements had been made since the new manager started working at the home in May 2015 as we saw evidence of audits carried out from May 2015 and copies of the 'home manager's daily audit' and 'manager's daily walk around'. Additionally, an incomplete quality monitoring report for May and June 2015 was provided to us by the regional operations manager following the inspection. The regional operations manager informed us that the audit was incomplete as it was still in progress.

We discussed feedback from people who used the service and their family members with the manager and regional operations manager. They told us questionnaires had been sent to family members two weeks ago and once completed were to be returned to the provider's director of operations. We also saw a 'Residents and relatives' meeting had taken place on 18 May 2015 to introduce the new management team. This was attended by four relatives. The regional operations manager also told us a staff survey was to be included in every member of staff's next payslip.

We saw records of staff meetings and saw the minutes for a senior staff meeting on 14 April 2015, with five attendees, and agenda items included sickness, medication, evaluating care plans and contract visits. We saw the minutes for a staff meeting on 16 April 2015, with 20 attendees, and agenda items included sickness, off duty, cigarettes, rotation of staff, hairdressing, laundry and garden patio. We saw a staff meeting schedule on the notice board and saw meetings were scheduled monthly for the remainder of the year.

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<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises<br><br>How the regulation was not being met:<br><br>The premises being used by the provider was not suitable for the purpose for which they are being used. The ground floor nursing unit was not appropriately designed and did not have suitable lighting for people with dementia. Regulation 15(1)(c). |

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met:<br><br>Care and treatment was not provided in a safe way for service users. Regulation 12(1).<br><br>You failed to protect people who used the service against the risks associated with the improper and unsafe management of medicines. Regulation 12(2)(g). |

**The enforcement action we took:**
We are taking enforcement action and will publish this when the inspection process is complete.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>How the regulation was not being met:<br><br>Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13(2). |

**The enforcement action we took:**
We are taking enforcement action and will publish this when the inspection process is complete.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>How the regulation was not being met:<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to support service users. Regulation 18(1).<br><br>Staff did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a). |

This section is primarily information for the provider

# Enforcement actions

**The enforcement action we took:**
We are taking enforcement action and will publish this when the inspection process is complete.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs<br>How the regulation was not being met:<br>The nutritional and hydration needs of service users were not being met. Regulation 14(1). |

**The enforcement action we took:**
We are taking enforcement action and will publish this when the inspection process is complete.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>How the regulation was not being met:<br>Service users were not being treated with dignity and respect. Regulation 10(1). |

**The enforcement action we took:**
We are taking enforcement action and will publish this when the inspection process is complete.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>How the regulation was not being met:<br>Accurate, complete and contemporaneous records in respect of each service user were not being maintained. Regulation 10(2)(c).<br>The quality and safety of the services provided was not being assessed, monitored or improved. Regulation 10(2)(a). |

**The enforcement action we took:**
We are taking enforcement action and will publish this when the inspection process is complete.