Turner Home

Turner Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection of Turner Home took place on 25 and 30 January and 8 February 2018, the inspection was unannounced.

Turner Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Turner Home is registered to provide nursing care and accommodation for up to 59 people; in an original Victorian building and in a more recently added annexe. At the time of our inspection 48 people were living at the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. During our inspection we became aware that the registered manager had been absent from the service since August 2017. The registered manager was also the nominated individual for the service. The nominated individual is responsible for supervising the management of the regulated activity provided.

There was an acting manager at the home and an acting deputy manager. During our inspection the trustees of the service appointed a general manager to support the management of the home.

At our previous inspection in August 2016 the service was rated overall 'requires improvement'. There were breaches of regulation 9 (person-centred care) and regulation 18 (staffing). This was because people were not receiving person centred care that reflected their preferences as to what time they wanted to be supported to get up out of bed; and there were not sufficient numbers of staff on duty at night to make sure that they could meet peoples care needs.

At this inspection we found breaches of regulation 9, 10, 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found there had been breaches of regulation 14 and 18 of Care Quality Commission (Registration) regulations 2009, as there had been a failure to notify the Commission of notifiable events.

We observed times when staff did not protect people's dignity or privacy, showed a lack of respect or were overly focused on the task at hand and not the person and any impact their actions may have. We also saw a lack of dignity in how people's daily notes and records were written.

We saw in people's care files that there was insufficient information on risk assessments and they had not always been updated to reflect current risks. Some risk assessments were missing background information

which would be needed to assess a risk and at times a necessary risk assessment was not in place.

The service provided was not in line with the principles of the Mental Capacity Act (2005). People's consent had not always been sought for the support they received. Care planning often did not demonstrate how decisions had been made in people's best interests. People's care plans lacked sufficient guidance for staff and did not give information on people's history, lifestyle choices and preferences.

The acting manager and deputy manager were unable to show us the system for reporting, reviewing and learning from incidents and how this information was used to inform the risk assessment process.

The administration and recording of medication was not always safe. The nursing staff did not have protected time when administering medication and they experienced distractions. Some administration records and the stocks and balances of some medication had not been consistently recorded; at times it had been recorded and the figures were inaccurate. This made it impossible to work out if the stocks were correct and therefore to be assured that the correct medication had been given to people. Audits of the medication system had not been effective.

We asked the general manager to undertake an audit of the system used to record and administer medication and the stocks on hand; and to report their findings to the Care Quality Commission within three days. This was completed.

The building was not always safe. Upstairs windows were not appropriately restricted. This was acted upon during our inspection to reduce risks. We also saw that a fire risk assessment had been completed and appropriate actions on known risks had not been taken in a reasonable timeframe. The general manager told us that action was now being taken.

Staff members had not received adequate training appropriate to their roles and people's care and support needs.

Some areas of the environment and practices at the home were institutionalised and detracted from creating a homely atmosphere. People told us that there were limited activities at the home.

In the absence of the registered manager who was also the nominated individual an appropriate alternative management structure had not been put in place. The home was not adhering to its own policies and there was insufficient oversight of the quality of the service provided to people.

People told us that the staff were nice. People's relatives told us that the staff were nice and had been supportive during difficult times. We observed some interactions between staff and people that were kind and personable.

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

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The system in place to identify and reduce risks to people's health and wellbeing was not effective.

Incidents and accidents were not always learnt from.

The system in place for documenting, administering and managing people's medication was not effective.

The building was not always safely managed.

Other checks and audits on the services of the building and equipment used by staff had taken place.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff had not received adequate training appropriate to their roles and people's care and support needs.

The principles of the Mental Capacity Act (2005) had not been followed. People consent had not always been sought. Care planning often did not demonstrate how decisions had been made in people's best interests.

People were supported with their healthcare needs.

The environment of the building had been adapted for some people's needs but not for others. In some areas the home's environment was institutional and not homely.

Is the service caring?

Inadequate

The service was not caring.

People were not consistently treated with respect.

People's privacy and dignity was not always respected.

There was a task and not people orientated culture at the home.

People told us that the staff were nice. People's relatives told us that the staff were nice and had been supportive during difficult times.

Is the service responsive?

Inadequate

The service was not always responsive.

People's care plans lack sufficient guidance for care staff to follow.

People's care plans did not give details on people's history, lifestyle choices and preferences.

People told us that there were only limited activities at the home.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager, who was also the nominated individual, was absent and an appropriate alternative management structure had not been put in place.

The oversight of the quality of the service provided to people was inadequate.

The CQC had not been notified of events that the provider was obligated to do so.

The home did not adhere to its own policies.

Turner Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 25 and 30 January and 8 February 2018, the first day of the inspection was unannounced. The inspection was completed by two adult social care inspectors.

Before our inspection we considered information we held about the service, such as the notification of events about accidents and incidents which the service is required to send to CQC. We also asked the registered provider to complete a periodic Provider Information Return (PIR). This is a form that we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with three of the home's trustees and fifteen staff members. We spoke on a one to one basis with 12 people who lived at the home and held a group feedback session that was attended by 17 people who lived at the home. We also spoke with three relatives of people living at the home and three visiting health and social care professionals.

We looked at 12 care plans for people who used the service, three staff personnel files, staff training and development records as well as information about the management and auditing of the service. We observed staff interaction with people who lived at the home at various points during the inspection.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe at the home. One person said if they did not feel safe they would tell staff adding, "I've never been in that position." Another person told us that if there were any problems they felt confident talking to staff.

There was insufficient information on risk assessments and they had not been updated to reflect current risks. Some risk assessments were missing background information which would be necessary to assess a risk. At times a necessary risk assessment was not in place.

For example, one person had recently experienced five falls in the evening over a two week period. These falls had been documented in accident forms which had remained in the accident book. A nurse told us that accident forms are reviewed only when the book was full and the accident records are then put into individual people's files; however this could take months.

We looked at the care file for the person who had fallen five times in two weeks. The falls risk assessment identified that this person was at high risk of falls. However the risk assessment did not offer clear guidance for staff to mitigate the risk of falls and the monthly evaluation of the risk assessment for the period of the five falls stated only, 'High risk'. The evaluation had made the same comment for the previous ten months. There was no evidence that the pattern of falls was reviewed or of recognising a period of increased falls or of taking proactive steps to reduce the risks from the person falling.

In another example we saw a person using the stairs with a wheeled walking aid a number of times. This was dangerous and when we drew staff attention to this they offered the person assistance. However this did not prevent the person again walking down stairs using a wheeled walking aid. We looked at this person's care file regarding risk of falls. He had been assessed in August 2017 as being at medium risk of falls. A document stated the person was to be, 'encouraged not to use the stairs due to his mobility, staff to stress that this is dangerous.' We discussed this with senior staff who told us that they reminded the person to use the lift. This is not a suitable risk management plan as it leaves the person at continued risk.

For some other people staff gave us differing information about the risks they could pose to themselves and others. Some people's actions placed themselves or others at risk, or their behaviour presented challenges for staff. People's risks assessments did not contain sufficient information to guide staff on how to minimise risks or support people when their behaviour was challenging.

The acting manager and deputy manager was unable to show us the system for reporting, reviewing and learning from incidents and how this information was used to inform the risk assessment process. We were told that completed untoward incident forms would have previously been given to the registered manager.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because risks were not effectively managed at the service.

We observed one morning administration of medication by staff. The staff did not have protected time when administering medication and they experienced distractions. The staff were polite and greeted people when administering their medication. Some people took a long time to take their medication and needed encouragement. However the circumstances made the staff rushed and they didn't always explain to people what was happening.

Medication was stored securely in locked cabinets. We saw documents that recorded what medication and creams each person was prescribed and offered guidance for staff. The administration of people's medication was recorded by signatures on a medication administration record (MAR). Some medication was blister packed into days and times by the pharmacy; other medication was boxed in its original packaging. The stocks and balances of boxed medication had not been consistently recorded, at times it had been recorded and the figures were inaccurate. This made it impossible to work out if the stocks were correct and therefore to be assured that the correct medication had been given to people. In the medication stocks for two people we noted four stock recording errors.

One MAR sheet we looked at was unclear and did not match with the stocks of medication that had been available. The nursing staff we spoke with were not able to show us how they could be assured that the person had received their medication.

We checked the current months morning blister packs for 15 people, 14 of these indicated that people had received this medication. One blister pack still contained a medication that should have been administered to a person 10 days earlier. We asked the nurse what action had been taken with regard to the missed medication and to see what record had been made of this error. No action had been taken and no record of this error had been made.

Controlled medication was stored in a second locked cabinet; this cabinet was too small to contain all the controlled drugs in stock which meant that some were stored inappropriately. We looked at the controlled drugs register, the stocks of controlled drugs were correct. However no periodic stock checks of controlled drugs had been recorded, for some controlled drugs over a period of three months.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the management of people's medicines was not safe.

We asked the general manager to undertake an audit of the system used to record and administer medication and the stocks on hand; and to report their findings to the Care Quality Commission within three days. This was completed.

The home is a Victorian building and was in a general good state of repair; substantial work was underway in replacing the roof. Recent work had also been done to replace windows in the original building. However we saw that some of the windows in the new annex were rotten and needed repair work. Also a number of windows on upper floors could be fully opened, up to 30cm. People could potentially exit the window from an upper floor. For the safety of vulnerable adults it is recommended that windows are restricted to an opening of 10cm. We spoke with the general manager about this and during our inspection work was taking place to correct this.

A fire risk assessment of the building had been completed in August 2017. This report highlighted a series of actions required, at the time of our inspection some of these had been explored and contractors had been appointed; but other areas had not. Areas that had not been addressed included ensuring fire barriers in the basement of rooms that posed a risk such as laundry and rooms containing the boiler and electrical

equipment. This is needed to provide a minimum of thirty minutes fire resistance to allow time for escape in the event of a fire. We spoke with the general manager about these; during our inspection they told us that reports were being commissioned from relevant professionals which would be followed up on.

A period of six months had elapsed since the fire risk assessment had highlighted areas that required action. Although actions were now being taken, this is too long to address known risks.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the building was not safe for its intended purpose.

During the inspection we were informed that a monthly building quality and safety check will now be put into place.

A series of checks and audits were completed at the home. We looked at the records of these and saw that the periodic report on the condition of the electrics had expired 12 months previously. This had recently been addressed by the staff at the home and a contractor was part way through the checks. However the recommended period for inspection had expired for some time before this was addressed.

Other checks and audits completed had been effective. Such as on the gas installation; PAT testing of portable electrical appliances; the passenger lift; the presence of asbestos; the hot and cold water systems and legionella testing. There were also regular checks of the fire alarm, emergency door closures and emergency lighting. Equipment used to lift people safely had been checked by competent persons.

We saw records that showed that staff received training on the use of fire extinguishers and the use of a fire sled for emergency evacuations. There was a mock evacuation of the building in January 2018 and each person had a personal emergency evacuation plan (PEEP).

The environment of the home was clean and free of odours. On one of the days of our inspection we spoke with the seven domestic staff that were on duty that day. They always had the equipment they need to do their jobs, received appropriate training and that senior staff were approachable with any concerns they may have.

We visited the laundry facilities and saw that they were well organised with safe systems in place for dealing with washed and unwashed laundry. Staff had access to gloves, aprons and hand wash and we saw that these were used throughout the day. We also saw that the appropriate protective equipment was used to care for a person who had a potentially infectious condition.

New staff went through a recruitment process to help ensure that they are suitable to work with vulnerable adults. We looked at the files of three staff members. Information about candidates was obtained through applications forms, an interview process, checking photographic identification, obtaining references from pervious employers, verifying references and obtaining or checking a DBS certificate. The human resources manager told us that it was practice at the home to accept previous DBS certificates if they had been issued within the previous three years. We asked the home to review this policy to ensure that their recruitment practice was robust and in line with current best practice.

Requires Improvement

Is the service effective?

Our findings

The staff member who was the lead in human resources told us that the homes policy was that fire safety, safeguarding, moving and handling, infection control and completing an NVQ was viewed as mandatory training for staff. This training policy does not cover all the standards required for care staff as outlined by skills for care in the care certificate. Skills for care are the government appointed body for setting standards of training in the care sector.

We also found that not all staff had completed the home's mandatory training. Moving and handling training had only been completed by 49 percent of staff; and a number of people at the home required support to move safely using wheelchairs and other walking aids, adapted baths and hoists. Therefore not all staff had received the training needed to provide this care safely.

There were other areas of concern with staff training. For example only 36 percent of care staff had received mental health awareness training; when a number of people at the home required support with their mental health and it is a core standard of the care certificate. Only 33 percent of staff had received training in nutrition and hydration; when a number of people required support with eating and drinking. Other similar examples of low percentages of staff receiving training were in health and safety, dementia awareness and person centred care. This meant that some staff were caring for people with a range of support needs that they had not received appropriate training to do so.

The statement of purpose for the Turner Homes states that; 'New carers will complete the care certificate within 12 weeks of employment, and complete a Level 2 Diploma within 2 years of appointment.' Records given to us did not demonstrate that staff completed the care certificate standards and only 35 percent of care staff were NVQ qualified or were undertaking an NVQ.

Staff training records were not kept in a manner that would enable senior staff to identify training gaps in their workforce. There was no evidence that audits of training had taken place to ensure that staff stayed up to date with their knowledge and skills. We looked at the home's induction pack, this focused on policies at the home. When we asked questions about how the induction was delivered we were told that this would usually be delivered by the registered manager who was absent.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff had not received sufficient training to be effective in their roles.

One senior staff member told us that they had started updating staff knowledge on a different policy each month. They showed us the system they used and some recent policies that had been reviewed including, whistleblowing, bullying and harassment and equality and diversity. They told us that this had been a useful way to ensure staff were aware of the home's policies without overloading them all at one time. Some staff had been supported by the organisation to obtain professional qualifications as part of their professional development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The home held a record of DoLS application made on people's behalf and who had a current DoLS in place. These records showed that senior staff had regularly contacted the relevant authorities to ask how the application was being processed.

Some people had documents that showed they had given their consent to care and accommodation at the home or that it was in their best interest; some people did not. There were many decisions made on people's behalf and we saw no record of how these decisions had been made, no record of the person's consent to the decisions or evidence of a decision being made in a person's best interests if they lacked capacity. Whilst these decisions may turn out to be the least restrictive options available there is no evidence showing how this was explored and how the person had been involved. Examples of these decisions included some people's access to alcohol, how much, what type and when. Some people's access to cigarettes, when and how many; and some people's access to their money, when and how much.

The CCTV system in the home had been expanded to include all communal and external areas of the home. Most people we asked told us that they knew the CCTV was there. One person said, "You can see them (the cameras)." The system recorded one month of images and was installed for the safety of vulnerable adults and had been used to investigate incidents or concerns. Whilst we understand the reasons for using CCTV there was limited information for people to inform them that CCTV recording was taking place in their home. As this is people's home we don't want to encourage multiple signs, however it needs to be clear that people are being recorded at the home. There was no information about CCTV in the service user guide, on the homes website and when we looked in people's care files. People's consent had not been sought.

During our inspection staff read best practice guidance on the use of CCTV and were in the process of ensuring they were following this correctly. For example the initial assessment document was changed to prompt staff to inform people of the CCTV policy of the home.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people's consent had not been actively sought.

The home does not act as appointee for finances for anybody living at the home; however some people had their monies paid into the home's account. Whilst these monies were accounted for separately, we informed the general manager that it was necessary to separate into different accounts the monies belonging to people living at the home from those of the organisation.

We saw records that were kept of people's income and expenditure. We were told that these were checked periodically; however we were not shown any of these audits. We recommended that these records were checked by a second person.

People told us that they can easily see a doctor when needed. One person's relative told us that if there were

any issues regarding their family member's health it got attended to right away. One social worker told us that they asked for a referral to be made and it was done straight away.

The Home has a treatment room that was used as a medication store and for visiting health professionals to see people. A screen to provide privacy was available. We were told that the provider has a contract with a local GP who visits weekly and sees any of the people living there who require a health appointment; the GP also visits to carry out emergency appointments at other times. We were told that people can also see their health professional in their bedroom but senior staff explained it was easier for the person to be seen in the treatment room. A person centred approach to this should be taken to ensure this is for the comfort and convenience of each individual and not for the convenience of staff and the visiting professional.

People were mostly positive about the food provided at the home. One person told us, "The food is good enough." Another person said it's "Not bad." A third, "Very good." Another person told us that the "Sunday roast is good", but told us that he has cereal for breakfast but would like a full English at times during the week.

We saw that on one day lunch was two courses, pea and ham soup and beef burgers with a second option of fish, chips and peas. We did observe that for five out of seven days this week the main meal was served with chips and it was the same for the menu the following week. We saw that in the kitchen there was a record of people's likes and dislikes. People told us that they had a choice of food. One person told us if you didn't like the food you could have a sandwich.

Some people required an easy to swallow diet. We saw that this food was prepared with care and presented in an appealing manner. One staff member told us, "It's important that people's food looks nice and people can recognise their food to make it more enjoyable."

We saw that the kitchen was clean and tidy, food was safely stored and there was records kept of cleaning and food storage and cooking temperatures.

Facilities were available throughout the building to support people with their mobility and personal care. This included ramps, handrails, a passenger lift and accessible showers and baths.

People living at Turner Home had their own bedrooms and we saw that these were well maintained in that they were all furnished and painted to a good standard, although some appeared bland. One person told us, "I have a good room, it's bright." The majority of rooms throughout were painted magnolia and we did not see any evidence that the environment had been adapted to meet the needs of people living with dementia. Senior staff did tell us they were planning to replace the main carpet as it was patterned and caused some people to hesitate when walking. We recommend that the service consider current guidance on adapting environments for people living with dementia and take action to update their practice accordingly.

Doors throughout were marked as to their use. Whilst signage can help people find their way round some of the signs were similar to those found in clinical or institutional environments, for example 'treatment room' and 'sweet shop.' People's doors had their name on but other than that did not appear personalised to help a person find or identify their room. Similarly a number of notices throughout the home for staff attention detracted from creating a homely environment. For example a note on a corridor wall advised staff on the homes, 'spillage policy'. We also heard a tannoy system that operated throughout the home which could be heard in communal areas. On this the office made announcements and requests for staff members to contact the office, this did not contribute to a homely atmosphere and we recommended exploring another method to contact staff at the home. One social worker told us they thought the home was, "Like an

institution, a bit stark. On the second day of the inspection senior staff told us they intended to change the room used as a sweet shop to create more of an experience and support people to reminisce. For example by introducing old fashioned sweet jars.

The facilities manager has a budget each month for renovating a room. This included liaising with maintenance if flooring needed replacing or walls redecorating. They told us that if the room was occupied they liaised with the person regarding their choice of colour before buying new bedding and curtains.

Inadequate

Is the service caring?

Our findings

We asked people what they thought about staff at the home. Most people were positive and told us that staff were kind towards them. One person said, "I get on with them all [staff]. They are all good. The nurses are nice." Another person told us the staff were, "All right."

One person's family member told us that, "Staff are very nice and welcoming." And that their relative, "Gets on well with the staff." Another person's family member told us that the staff looked after her when her relative was ill; they were very welcoming and made arrangements that made them comfortable whilst visiting their relative. They told us, "Nothing is too much trouble for them. I watch and I see good care." One visiting social worker told us that they thought, "The staff have a fondness for people and are very welcoming"; and that the person they spoke with had made friends at Turner Home. Another visiting social worker told us about the service and staff, "Can be institutionalised but the people (staff) are nice."

On occasions we observed staff being kind and personable in their interactions with people. It was clear that some long standing staff knew people well and had good relationships with them.

We also observed times when staff did not protect people's dignity, showed a lack of respect or were overly focused on the task at hand and not the person and any impact their actions may have.

Examples of this we witnessed are; on one occasion we were told to "come in" to a room when a person was receiving personal care. This showed a lack of respect for the person and did not protect their dignity. On another occasion a bathroom door was left ajar, when a person was being supported to bathe. We also saw that some staff did knock on a people's doors but then entered and didn't wait and allow time for the person to answer. At times staff members also entered people's rooms and were completing tasks before addressing the person who was in their room. We were sitting down and speaking with a person when a member of staff came in-between us and mopped around the person's feet. We saw multiple boxes marked as continence aids were stored in the home's chapel on pews, visible to all. We saw one staff member drag a person in a dining chair like a sledge from behind without speaking with the person, telling them what they were about to do or asking their permission.

We also saw a lack of dignity in how people's daily notes and records were written. These were not written in a respectful manner and concentrated on providing information on how people behaved; for example 'wandersome' and 'pleasant and cooperative'; or on what care was provided to them; for example 'routine checks maintained' and 'medication and supper taken'. Continence care and personal care given'. They provided little information on how the person had spent their day or anything they had or had not enjoyed doing. Daily records also used terms such as; 'complied', 'let us' and 'refused'; which implied that the person should do as they are asked by staff. We were told by the acting deputy manager that daily notes were completed by nursing staff and not the care staff who provided the majority of people's care.

We also became aware during our inspection that people at the home used communal socks. There was no system for identifying which socks belonged to whom, or of keeping them separate in the laundry. This

meant that the same socks may be worn by many different people living at the home. We were told that each person was given three pairs of socks, which were not necessarily theirs. When we spoke with the acting manager and acting deputy manager they defended the practise as being practical because of the difficulty in identifying different people's socks. They did not recognise this as being disrespectful to people and taking away people's dignity.

On the second day of our inspection we saw that mesh bags had been purchased to keep individual people's clothes separate in the laundry.

We saw that where people had their own towels their name had been written across the towels in black marker pen. A more discreet method of marking people's belongings would be more dignified.

Domestic staff entered lounge areas to clean whilst people were watching television. This is intrusive and we did not see any evidence that people were consulted or cleaning duties arranged taking into account that the building is also people's home.

These examples showed us that there was a task orientated, institutionalised approach and culture at the home. This inevitably meant that people were not treated with dignity and respect. The home statement of purpose states, 'Your dignity is a matter of prime importance to us, and all staff receive training in this area.' The records provided by the home show that only 28 percent of staff had received this training. The staff at the home lacked thought about and had become complacent in this area.

These examples collectively demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because service users were not always treated with dignity and respect.

A large room on the first floor was unlocked and we were able to enter this room which appeared to be used for records storage. The contents of the room included financial information and care records for people living there or who had lived there and personal staff information. We brought this to the attention of the acting manager and the room was secured. People's current care plans and other documents were safely stored.

Care records for one person clearly identified who personal information could and could not be shared with. This was good practice as it lessens the risks of people's right to confidentiality being breached.

Inadequate

Is the service responsive?

Our findings

Before people came to live at Turner Home staff obtained information about the person and their support needs. This included a care plan from service commissioners, discharge information from the hospital in addition to which a senior staff member carried out an assessment of the person's needs.

These documents provided information on the person's physical and mental health support needs and any risks that might be involved in providing the person care and accommodation. However we saw little information on the person choices, hobbies or lifestyle. Care plans focused on tasks and risks and not on people's preferences regarding their care and lifestyle. Some staff knew people's preferences and reacted accordingly; for example telling us that one person likes to lie in in the morning, so they won't disturb him. However people's care plans did not routinely offer staff this information.

The home was efficient and in some aspects ran smoothly. However because of a lack of individualised support planning the service was often not person centred. An example of this is that all people used the same toiletries as the home bulk purchased toiletries and periodically distributed them to people. A member of staff explained they took a trolley around every week to stock people's bedrooms. They also told us that if someone requested a different brand then they would supply this and had done so on occasions in the past.

We saw that people's care plans were reviewed monthly. However we saw very few changes resulting from these reviews. We highlighted in the safe section of this report when accidents had not resulted in any change to a person's care plan during the review. One social worker told us about one person's care file they had been looking at, "The staff seem to know [name] well. But I'm not so keen on the paperwork. Its states 'no changes', 'no changes' month after month for two years."

People's risk assessments lacked sufficient detail which meant that the corresponding care plans lacked sufficient guidance for staff on how to support people well. For example one person's risk assessment stated that the person 'has a history of aggression'. The aim of the care plan was identified as, 'to maintain [name's] safety'. However it did not identify the type of aggression the person presented with, how to best support the person if they became aggressive or what may cause this person to become aggressive and how to best support them.

Another person's care plan also stated that they had a history of aggression and this was related to times of personal care and changing his clothes. We looked at the records of the previous year and saw that all the documented times of aggressive behaviour related to the person's tobacco and cigarette lighter. The care plan had been review twice during this time but no adjustments had been made. This meant that the current care plan did not reflect the person's needs or offer guidance for staff on how to best support this person.

A third person's care plan stated that the person, 'required assistance with his personal care.' It gave brief guidance to prompt the person with encouragement for personal care and changing clothes. However it was

not specific as to how the person preferred their personal care, for example did they have a bath or shower, did they use any aids, what prompts and encouragement the person may need during personal care, did they need any physical support and did they chose their own clothes.

Some documents in people's care files referred to the home having a locked door policy, this sounded like a blanket approach and we were concerned by this. Turner Home is a nursing care home with some people having a DoLS in place to protect their legal rights; it is not a locked unit. It was not recorded clearly in people's care files what level of support people would need to access their community and if they were allowed to do so independently.

A trustee told us that the policy was that; if there are risks there is a locked door policy. However in practise people are treated as individuals. The policy in place was not a 'locked door policy', however some staff believed that one was in place. This detracted from treating people in a person centred manner.

Three people told us that breakfast was timed. One person said, "Staff say 'hurry up'. You have got to be up by nine." When we asked why they said, "Breakfast." A second person told us, "You can get up when you want." Then added, "If you want breakfast you have to be up." We spoke with the acting deputy manager about this and they told us that this was not the case. We did see people finishing off their breakfast at 10:30am. However we were concerned that some people in the home had the perception there were rules in place regarding their mealtimes.

It was not always clear in people care files what equipment people use to walk around safely. In one person's care file, it was stated the person required a 'Zimmer' or 'walking frame' and in a different place a 'walking aid' with no description. The type of walking aid was not detailed, for example one with wheels or without wheels. We saw another person using a walking frame. His family told us he had said this was not his frame. The person told us, "it is too low." We looked and saw that it was not marked or identified who it belonged to. We asked a member of staff to look into this. We then looked at another two people's walking frames, one person's had initials marked on that were different to their initials and another person had an unmarked walking frame. The care planning and staff practice did not ensure that people were using their personal equipment. This showed that there was not a person centred approach regarding people and the equipment they were assessed for, to keep them safe.

Records given to us by the home's human recourses lead showed that training in person centred care had only been completed by 12 percent of care staff members.

These examples collectively demonstrate a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because care provided to people was not person centred.

When we asked people about their care plans one person told us, "If you want to know anything, you can ask them (staff)." One relative told us that they were asked for information in putting together the care plan for their family member. They told us that although they didn't look at it they knew they could at any time. We did see examples when sensitive confidential information was dealt with appropriately.

The newly appointed general manager told us that it was one of his priorities to review the care planning processes in place at the home and to review each person's individual care plan to ensure that it was appropriate and reflected their needs and preferences.

During our inspection in August 2016 we noted that; 'People were not having enough person centred activities provided by the service to promote their wellbeing.' This had not improved; during this inspection

there was a clear consistent message from a number of people that there was not much to do at the home and they wanted to do more. One person told us, "I've been here 10 years. I haven't been out in ages, there's not much happening." Another person told us, "There's nowt to do here. It's like a prison away from prison." A third person said, "I don't get out enough. I don't know why." When we asked one person what would make it better they said, "If I could go out." He told us he could not go out, "In case I fall." He added, "I think I could go out on my own its rubbish."

One family member told us that sometimes their relative does go out with staff but said, "It depends on who is on if he goes out."

Whilst we recognise that there may be a variety of reasons why a person may need support to leave the home rather than going out alone; we saw very little in arrangements to periodically ensure this happened or very little evidence of activities happening in the home.

The home's statement of purpose states that they actively promote service users social network and social activities. Also that a record of life history, social network and preferences for activities and hobbies are made. Adding, 'The service user is offered access to those networks and activities which are appropriate and desired.' A guide to the Turner Home which we obtained from their website during our inspection stated, 'Those who can travel are taken to Jersey or the Isle of Man, whilst others enjoy a holiday in this country. In addition long weekend and day trips are arranged throughout the year.' We saw no evidence of this.

At the home, there were three lounges, called lounge one, two and three along with a dining area that adjoined lounge one. During our inspection we saw that lounge one adjoined the dining room and could be noisy, there was no TV or music playing in this lounge. Lounges two and three had TV's on daytime channels. After breakfast in lounge two we saw a group of men sitting in a large room with an average sized television in a corner showing a program about younger people buying houses in the countryside. Nobody was paying particular attention to the TV or appeared to be enjoying it.

People had a 'social activity and leisure record' document in their care file. We looked at one person's 'social activity and leisure record' in their file. There was evidence of more activities in previous years, however more recently there was very little information. In 2017 there were mostly one line entries on the person's record each month. For example in September 2017 the record stated; 'Balloon throwing in lounge… did not join in.' We asked one person about their interests and hobbies and they told us at the home there is, "Not very much to do." We asked another person what they were doing today and he told us, "Not much, have a few smokes." A third person told us, "I haven't been out in ages, there is not much happening."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because care provided did enable people to participate in their community and in activities that promote their wellbeing.

The building was built with an integrated chapel. The acting manager told us that periodically local clergy conduct services that people at the home can attend.

We did see that there had been an increase in activities the previous month - December 2017. This was when the home appointed an activities co-ordinator. We spoke with the activities co-ordinator who told us they worked five days per week approximately eight hours a day. This was generally daytime hours but is flexible to meet the needs of people living there. For example when the Liverpool Derby match was playing he had worked the evening so that those who wished to could watch the match in the activity room. We found that although in post a limited time the activity coordinator was getting to know people's hobbies and interests.

He was knowledgeable about some people's individual interests and hobbies and was making plans to support people to explore these. On the second day of our inspection we saw some people sitting with the activities coordinator playing board games and cards as well as having a chat. One person told us that they liked the games room.

The activity room on the first floor and contained board games, books, DVD's, items on local history, table hockey and table football and a pool table that was due to be replaced. This was a bland room that was messy and uninviting we were told plans were in place to decorate this and make it a more inviting room. We were also told plans were being made turn an underused room into a cinema room.

We were told by the acting manager and acting deputy manager that the home had not received any formal complaints. If any had been received before the registered manager was absent they did not have access to these. We were shown a copy of the home's complaints policy which was clear and in the home's statement of purpose there were the details of and contact numbers for outside organisation that people may wish to raise concerns with, such as the Care Quality Commission.

Inadequate

Is the service well-led?

Our findings

During this inspection we became aware that the registered manager who was also the nominated individual had been absent from their roles since August 2017. The nominated individual is responsible for supervising the management of the regulated activity provided. It is a legal requirement of providers to notify the Care Quality Commission of absences of more than 28 days. This had not happened.

The provider was also obligated to notify the Care Quality Commission of the granting of any Deprivation of Liberty Safeguards. The Care Quality Commission system shows that this happened three times in 2017. Records at the home showed that six DoLS had been granted in 2017. Meaning that the CQC had not been notified of all granted DoLS as required.

These are breaches of Regulation 14 and 18 of Care Quality Commission (Registration) regulations 2009. Failure to notify the Commission of notifiable events.

Turner Home is a registered charity which has a board of seven trustees. During our inspection period the trustees appointed an interim general manager to support the acting manager and acting deputy manager in the absence of the registered manager who was also the nominated individual. We saw during our inspection that this additional support from the general manager was having a positive impact.

The trustees met together monthly with professional advisors and also the acting manager or acting deputy manager. The trustee's arranged for 'visitor's reports' to be produced from visits made to the Turner Home by a trustee. We saw records of these visits in December, November, July and June 2017. These reports focused on the building, the environment and speaking with staff members. There was very limited attention to the voice of people living at the home. Management arrangements and systems at the home had also not been reviewed or spot checked by the 'visitors reports' or by any other method in the absence of the registered manager who was also the nominated individual.

The management and staff at the home were proud of the over one hundred year heritage of the Turner Home. As expected over time there had been many changes to the practices at the home. However we found the vision and strategies at the home to not be in line with current best practice. The home whilst being efficient still had an institutionalised feel and manner. Examples of this are given throughout this report in care planning, risk assessing, interaction between staff and people supported, consulting with people supported and making sure that the care provided reflected people's preferences and needs. A lack of a person centred culture at the home had not been recognised or addressed by senior staff.

The home had an extensive body of policies and procedures in place. However as demonstrated in this report they did not guide day to day practice. Some examples include the home's policy on incident and accident recording was not followed by staff to enable learning from these incidents and the improving of people's support as a result. This policy was in place from 2015 and was reviewed in 2016. We asked two nursing staff on duty how this form was used. One nurse told us, "I've never seen that one"; the other nurse told us, "I've been here seven years and not used it." We later saw that a different form (Untoward incident

report) had been used as we saw a couple of examples of them completed in people's care files.

The home's CCTV policy states that a record should be made of people who accessed or took copies of the CCTV images. No such records had been kept and no system was in place to make such records as recommended by the policy. We recommended that there is a system put in place to record who had access to these images. The home's policy on 'complaints, suggestions and compliments' states that a register is in place for these, nobody could show us this register. Also the homes training policy had not been followed in that people had not received the required training.

Some audits, checks and reviews at the home had not been effective or missing. For example there was no system for checking that staff members had received adequate training for their roles as the training provided to staff had not met core standards and did not equip staff for the varied support needs of the people living at the home.

The medication audits had not been effective and were not fit for purpose. We looked at the monthly medication audits for the previous four months; the acting manager and acting deputy manager told us that they completed these audits, however these were not signed. The audits asked questions to be filled in by a tick box and showed that everything relating to medication was in order. The four audits stated that a stock check had been completed of controlled drugs; however no stock checks had been recorded. The audit also stated that weekly spot checks had been completed to check individuals stock balances against MAR sheets and stock balances completed prior to re-ordering. The acting deputy manager who completed some of these audits told us they didn't do the spot checks and the stock balance was a visual check to see if more medication was needed.

We also asked senior staff what procedure was in place to record and learn from medication errors. We were told by that there had not been any medication errors for 12 months. There were no incident or medication error forms completed. We found a number of errors relating to the recording of people's medication. The medication audits had not been effective and could not be relied upon to demonstrate that the acting manager and acting deputy had oversight of the administration of medication. We saw that when a medication error had been made 10 days earlier, this had not been recorded or acted upon when it was instantly obvious to anybody who accessed this person's medication during this 10 day period. This left people at risk of their medication not being managed safely.

The acting manager and deputy manager was unable to show us the system for reporting, reviewing and learning from incidents; they told us that previously completed untoward incident forms would have been given to the registered manager. As detained in the safe and responsive sections of this report, we saw examples during our inspection of how this impacted people's care.

An accident book was being used; we saw a number of these books that had been filled in with the records of trips and falls experienced by people. The acting manager told us that when the book was full the records were photocopied and put into individual people's files and the records would be reviewed in this way. We were concerned about the length of time taken to review these records and how risks would be assessed and mitigated in the meantime. For example we looked at one book and found that one person had fallen over in the evening five times in a two week period, two months earlier and this had not resulted in a review of his care plan. Because there was no system in place to review these accidents in a reasonable timeframe.

The acting manager and acting deputy manager had been entrusted with oversight of the service by the charity's trustees in the absence of the registered manager who was also the nominated individual. However no supernumerary time had been allocated for the completion of management tasks; giving them little

capacity to fulfil these roles. Both the acting manager and the deputy manager were qualified nurses and were on the nursing shift rota full time. Meaning that there had been no allocated management hours at the home for five months.

There was a lack of oversight of the quality of the service provided to people. The home was not following best practice guidance which had led to people receiving a service that was institutional.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the oversight of the quality of the service was inadequate.

We observed the acting manager and acting deputy manager to be very busy and involved in many different aspects of the day to day running of the home; with constant demands from their nursing and managerial roles. The acting manager was also the clinical lead for the home. The acting deputy manager told us of recent times when they had also covered night shifts due to a shortage of nursing staff. The acting manager and acting deputy manager told us that some administration staff had taken on extra duties and that they had tried to recruit extra nursing staff but had found this difficult.

We saw that since the time the acting manager and acting deputy manager had been in post some changes had been made or planned. There was a full time activities co-ordinator appointed, a computer and the internet was installed in the nurses working area and an electronic care records system had been commissioned to help improve the quality of information held in people's care files. The managers were very positive about the home and their roles and told us that they were happy to be supporting the home during the manager's absence; it was clear that the home was important to them as individuals and both had worked at Turner Home for many years.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 Registration Regulations 2009 Notifications – notices of absence Failure to notify the Commission of notifiable events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to notify the Commission of notifiable events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not actively sought.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not effectively managed at the service. The management of people's medicines was not safe.

The building was not safe for its intended purpose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The oversight of the quality of the service was inadequate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received sufficient training to be effective in their roles.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care was not provided to people in a person centred manner. Care provided did enable people to participate in their community and in activities that promote their wellbeing.

The enforcement action we took:

Issued a warning notice.