Indigo Care Services Limited

Paddock Stile Manor

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**

Summary of findings

Overall summary

This inspection took place on 15 and 18 September 2017. Both days of inspection were unannounced. We last inspected Paddock Stile Manor on 1 February 2017 and found the provider had breached a number of regulations we inspected against. Specifically the provider had breached Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically, the risk assessment process had failed to ensure all risks had been identified and assessed. There were discrepancies in relation to the frequency of overnight checks and positional changes which meant people may not have been receiving appropriate care and support. Nurse call bells in communal areas had been tied up out of people's reach so they would be unable to use them if they needed to call for help or support. Fire exits had been used to store items and personal emergency evacuation plans contained incorrect detail and were not in place for every person living at the home.

We found the provider had failed to implement effective governance systems in relation to premises and equipment safety and care documentation. We also made a recommendation about the recording of mental capacity assessments and best interest decisions.

Following the inspection the provider had submitted an action plan, offering assurances that the required improvements would be made by 28 April 2017. During this inspection we found evidence of continued and new breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Paddock Stile Manor is a care home with nursing for up to 40 people. It is a purpose built care home spread over two floors.

At the time of the inspection there were 30 people living at the home, some of whom were living with a dementia. 13 people resided upstairs and had been assessed as needing nursing care and 17 people lived downstairs.

The service did not have a registered manager. The current manager had been in post since March 2017. In August 2017, they had submitted an application to the Commission to be registered. The previously registered manager had left their post on 13 February 2017.

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.

We found there were ongoing concerns in relation to the assessment and mitigation of risk. This included the accuracy and completeness of personal emergency evacuation plans. A failure to assess risks in relation to epilepsy, contradictions in relation to mobility and falls assessments and failure to assess environmental concerns.

Care documentation did not provide staff with sufficient information and detailed strategies to support people safely.

People's medicines were not managed safely. Two people had not received their medicines as prescribed. There were gaps in the recording of medicines and appropriate guidance was not always in place.

Everyone we spoke with raised concerns about staffing levels. A dependency tool was used to assess people's needs but we could not be sure this was accurate. The manager also raised concerns that the dependency tool was corrupted.

There was a reliance on agency staff, particularly nurses. This meant, given the failure to ensure accurate, up to date and complete records people were at risk of receiving care which was neither safe nor appropriate.

The concerns noted in relation to DoLS applications and authorisations meant people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

Staff had not received appropriate induction, supervision and appraisal which meant they had not received the appropriate support to enable them to fulfil their role and meet people's needs.

We observed people were not treated with dignity and respect. We saw one staff member ignore someone who was showing signs of distress. Some staff referred to people by their room number rather than their name. Relatives raised concerns that people's personal appearance was being neglected. We also observed poor moving and handling practice.

We have made a recommendation about the provision of meaningful activities for people living with a dementia.

Quality assurance and good governance had not been established, audits had not been completed in a timely manner and they were not effective in identifying concerns and areas for improvement.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were ongoing concerns in relation to evacuations and fire safety.

Peoples' medicines were not managed safely and some people had not received their medicines as prescribed.

Everyone we spoke with raised concerns about staffing levels, and felt there were not enough staff to support people.

Is the service effective?

Inadequate

The service was not effective.

The principles of the Mental Capacity Act 2005 had not been followed and Deprivation of Liberty Safeguards were not appropriately monitored. One person was being deprived of their liberty with no authorisation in place.

Staff had not received the appropriate induction, support, supervision or appraisal to enable them to fulfil their role.

People told us they enjoyed the food which looked appetising.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives told us staff were caring but there were not enough of them and this impacted on the care they received.

We observed some care staff ignoring people in favour of completing records. We heard staff refer to people by the number of their bedroom, rather than their name.

Relatives told us people's personal appearance was neglected, and one person said they had not had a bath for the past eight months.

Is the service responsive?

Inadequate

The service was not responsive.

There were ongoing concerns since the last inspection in relation to the lack of detailed strategies within care plans for staff to follow.

We observed staff failed to follow the guidance documented in mobility plans which placed people at risk.

Activities were offered but they were not meaningful for people living with a dementia.

Complaints were recorded.

Is the service well-led?

Inadequate

The service was not well-led.

There were continued failings in relation to quality assurance and governance.

The action plan the provider submitted following the last inspection had not been adhered to and the necessary improvements had not been made.

Audits had not been completed in a timely manner and actions had not been taken to improve the service.

Paddock Stile Manor

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 18 September 2017 and was unannounced. This meant the provider did not know we would be visiting.

The inspection team was made up on three adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed 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 what improvements they plan to make.

We also contacted the local authority commissioning team, CCG and the safeguarding adult's team.

We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with six people living at the service and three relatives. We spoke with the manager, the regional manager, and two registered managers from two other of the providers locations, one of whom was on shift as the nurse at Paddock Stile Manor. We also spoke with five care assistants, three senior care staff, the activities coordinator, one nurse and two agency nurses.

We reviewed seven people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine records, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

During the last inspection on 1 February 2017 we found breaches in regulation. Nurse call bells in communal areas were tied up and out of reach. Fire exits were used to store items. Personal emergency evacuation plans (PEEP) were not accurate, room numbers were incorrect, one person did not have a PEEP and another person was not on the evacuation list. Risks, such as choking and epilepsy had not been assessed.

During this inspection we found there had been no improvements made in some areas.

Nurse call bells were no longer tied up and were accessible for people, and fire exits were no longer used for storage. We found ongoing concerns in relation to PEEPs and the management of risk. We also raised concerns in relation to staffing and the management of medicines.

Following the last inspection the provider submitted an action plan which identified how they would improve. This included a monthly audit of PEEPs. We found no evidence that this had taken place and there were continued concerns, two people did not have PEEPs and we found a further two people were noted as living in rooms which they did not live in. We spoke with staff about the building plan and evacuation procedure and they were unclear about how they would evacuate people.

The provider's fire safety policy stated, 'All staff must take part in a fire drill at least once every three months.' We found 55% of staff had not completed a fire drill within three months. We raised this with the regional manager who said, "The training matrix is every six months, the policy must be wrong." We sought assurances and the manager and regional manager confirmed fire drills would take place with all staff on duty on 15 September 2017 and over the weekend. They also assured us agency staff would be included to ensure they attended a drill. On day two of the inspection we were informed only one fire drill had taken place on Saturday 16 September 2017 so assurances had not been met.

With regards to evacuation the fire safety policy stated, 'One member of (care) staff from each floor/department, all ancillary staff and the manager/senior in charge must attend the fire panel.' It also stated, 'Always ensure that residents in unaffected areas are not left unsupervised.' PEEPs documented the number of staff people needed to be supported by to ensure a safe evacuation. We noted there were insufficient staff available, at night, to follow the policy and the PEEPs. We raised this with the regional manager and manager who explained they had not really looked at the policy, PEEPs and staffing in that way and were going to raise it with the nominated individual.

A fire risk assessment was in place which had been completed in March 2017. We noted there were significant findings assessed as high risk which had not been addressed. This included that 'a time could not be given for the safe evacuation of the most difficult, single protected area in a fire scenario, with the night staffing levels, using phased evacuation.' There were also 35 findings which were assessed as medium risk, i.e. work should be completed within six months, with no actions recorded. The registered manager said, "Some actions have been done and others have been passed on to estates." We shared our concerns with the fire service.

On day one of the inspection two inspectors were using the lift from the first floor to the ground floor, they were unable to ascertain which control button to use as two buttons were missing from the panel and the other two buttons did not operate the lift. There was no indication of which button to press to open the doors so they sounded the lift alarm. Staff could be heard commenting that it was the lift alarm but took no action. It was only when a staff member on the ground floor called for the lift that inspectors were freed. This took approximately five minutes. We raised with the regional manager and manager that the lift panel had not been replaced since the last inspection and had resulted in inspectors being stuck in the lift with no initial response from staff.

We reviewed medicines management systems and observed medicines administration. We found two people had not received their medicines as prescribed. For one person it was noted that their medicine had not been received but no action had been taken to source it. Another person had missed one medicine for 14 days. Staff had commented that the person's behaviour and sleep pattern had changed but had not linked this to the missed medicines.

Protocols for 'as and when required' medicines (PRN) were completed however they did not provide detail in relation to how people would communicate if they were in pain. Care staff did not routinely record the time and reason for administration on the reverse of the medicine administration record (MAR). This meant people were exposed to the potential risk of overdose as requirements to ensure appropriate timeframes between doses were not being monitored. PRN protocols did not inform staff of behaviours that people may display which might indicate they would need their PRN medicines administered. One person was prescribed PRN lorazepam, which had been administered, but there was no protocol in place to guide staff as to when this should be administered. This meant we could not be sure they had been administered appropriately.

Some people had letters from their GP authorising the use of covert medicines. Covert medicines are medicines that are hidden in foods so the person does not know they are taking them. There was no evidence of mental capacity assessments in line with the Mental Capacity Act 2005, nor were there instructions on how to administer these medicines covertly. This meant we could not be certain this was the least restrictive way to support people with medicines. Nor could we be sure that the method of administration had not compromised the effectiveness of the medicine.

Body maps and charts were used to record the application of medicines which were administered via a patch placed onto the skin. These records were not always fully completed so we could not be sure that the patches were applied as prescribed.

Medicines care plans included a list of people's medicines, however for one person the list of medicines had not been updated to their current prescription.

We observed three people on the ground floor who required the use of hoists to transfer. During transfer care staff did not apply the brakes to the wheelchairs people were being transferred to. This presented a risk of falls due to equipment being unstable.

We also noted works were being completed on the ground floor to move the treatment room to the senior's office so there was more space. The bedroom next to the senior's office was being used by the workmen. On day two of the inspection these rooms were not locked and inspectors noted the bedroom presented a risk due to tools and equipment being in there, alongside care documentation. In addition the care documentation was not stored securely and confidentially as workmen had access. We discussed this with the manager who said, "There no risk assessment for the work on the office. I told them the doors should be

locked when staff weren't in them." We sought assurances that a risk assessment would be completed due to the potential risks to people living with a dementia walking into the room, as well as risks to visitors and staff being in the general vicinity of the works.

We found there was continued evidence of a failure to assess and mitigate risk. For example, one person's Personal Emergency Evacuation Plan made reference to the person 'suffering from epilepsy.' We reviewed the person's care records and found no support plan or risk assessment was in place. Staff we spoke with were unable to confirm if the person had epilepsy. The manager was unable to give any explanation as to why no supporting documentation was in place. They told us, "I think [person] had seizures before but have had none while here."

One person had a falls history assessment and risk assessment which stated on 12 September 2017 they were at low risk of falling. A falls risk assessment completed on the same date confirmed a score of nine which is within the assessment of high risk.

These concerns were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment

All the relatives we spoke with raised concerns that there were not enough staff. One relative said "I think [family members] safe here but there's not enough staff." Another relative said "The girls are all very good but they need more, they just don't have enough time. It's not as good as it was". A third relative said, "They need more staff." We asked one person if staff popped in to their room to check on them or to say hello. They told us, "No, they don't come in unless it's to bring you something or give you your tablets."

People told us nurse call bells were responded to quite quickly and we did not observe people waiting for significant periods of time for care and support. We did observe that some staff knew people well but other staff did not seem to know people and there was limited engagement and communication. There was a focus on the completion of tasks and we did not observe staff actively engaging and interacting with people in between the completion of tasks.

On the nursing floor there were two care staff and one nurse to support 13 people. Staff told us this was not enough. One staff member said, "It's not enough, there's challenging and unpredictable behaviour, apart from two people everyone needs two to one care so the nurse has to watch the floor. We can go downstairs and get someone from that floor. All we are told is according to the dependency tool we have the right amount of staff." We were also told, "People are normally got up by night staff who finish at 0800. It sometimes can be 0930 when everyone's up. We like everyone up before we do breakfast." They added, "Four people need support with meals." This meant some people's choice may not have been respected and others may have been up for a significant period of time before being offered any breakfast.

We observed the nurse did not respond to the nurse call bell on day one of the inspection as she was completing the medicines round, this meant when the two care staff were supporting someone, all the other people had to wait for support.

On the ground floor, there was one senior and two care staff to support 17 people. We were told, "Four people need two staff to support with hoisting and three people need one to one support when mobilising." This again meant that people would need to wait for support.

There was a reliance on the use of agency staff, particularly nurses as there was only one permanently employed nurse available. On day one of the inspection we were sent a rota which identified there was no

nurse on shift on Monday 18 September 2017, there were also gaps in relation to care staff cover. On Monday 18 September 2017 the nurse was expecting an agency nurse to arrive at 8am but this did not happen. The administrator told us they thought a peripatetic nurse was due on shift. The manager said the nurse had been informed over the weekend that a nurse from one of the providers other locations would be arriving at 1000am to take over. There was no documented contingency plan in place for staffing levels. There were also two occasions in July 2017 when a nurse had worked for 24 hours and another when they had worked for 36 hours. The manager had told the nurse they could go to sleep because there was an extra care worker on site but a risk assessment had not been completed.

A dependency tool was used to calculate staffing; however we found concerns in relation to the accuracy and completeness of care documentation so we could not be sure people's needs had been appropriately assessed. This may have impacted upon the dependency score. When we discussed this with the regional manager they said of the dependency score, "Oh that can't be right there must be something wrong with the spread sheet." The manager advised, "We identified an error on the dependency tool as one of the boxes that scores had been overridden." This meant we could not be sure the dependency tool was calculating the staffing levels correctly.

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing

All the people we spoke with confirmed they felt safe. One person said, "They're all very nice here and look after you. I know there's always someone at hand if needed." A relative said, "[Family member's] safe here but there's been a couple of incidents with the lady across the corridor coming into [family members] room and taking things." They added, "Things seem ok now".

One staff member said, "I would report any risks directly to the manager but if it was about the manager then I would raise this to CQC and safeguarding." Another told us, "If there are any risks I take them to the senior or to the manager. If it's about the manager or anything else I'm unsure where to escalate this to."

We saw safeguarding concerns and accidents and incidents were documented however there was no detailed analysis evident to identify trends or areas for improvement. The regional manager explained that electronic systems were being rolled out which would improve and support accident and incident recording and analysis.

A robust recruitment and selection process was in place. Full employment checks were conducted prior to applicants starting work these included obtaining references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people.

Inadequate

Is the service effective?

Our findings

During the last inspection we recommended the provider reviewed best practice guidance around retention of best interest decision assessments as detailed within the Mental Capacity Act 2005 Code of Practice at paragraphs 4.60 and 4.61.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager had a matrix in place for the recording of DoLS information which documented the date of applications and the expiry dates. We noted that one person's DoLS expired on 11 September 2017 and the matrix had not identified this so no new application had been made. The manager confirmed no new application had been made and offered assurances that this would be completed. This person's liberty was being restricted without the appropriate authorisations. We noticed other people did not have current DoLS authorisations in their file but the manager requested copies from the local authority as they had been granted.

We saw mental capacity assessments and best interest decisions had been documented however they were not decision specific. They related to decisions about, 'care and whether a DoLS is required.' We also found some paperwork in relation to DoLS applications and authorisations were not available so it was not clear whether people had conditions on their authorisations and whether they were being followed. This meant there was a failure to ensure appropriate monitoring and application of the Mental Capacity Act 2005 and associated Code, including the Deprivation of Liberty Safeguards in relation to service users who lack capacity.

These concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Need for Consent

We reviewed the induction, training, supervision and appraisal staff received to ensure they were appropriately supported to fulfil their role. We saw agency staff did not always receive an induction into the service. This included agency nurses who on night duty would have been the senior person on duty. This meant they had no knowledge of people's needs and what action to take in an emergency.

We spoke with a senior care worker who said they were from one of the providers other homes and had been asked to cover a shift. They said they had received an induction by the administrator and had been shown the fire zones and exits. We asked if any information had been shared about the people living at Paddock Stile Manor, they said, "There was nothing raised about specific residents or risks at handover today and if there was anything to raise it would happen at the handover meeting." We observed the handover on the ground floor and noted specific information about people's health and welfare was shared, including that one person was experiencing some increased pain, another person had been 'agitated' and another had been 'verbally aggressive'. This meant we could not be sure this staff member was aware of people's specific needs or current presentation.

Staff told us they had attended training when they first started in their roles and one staff member said they felt supported.

Of the seventeen care staff identified on the training matrix 41% had moving and positioning practical training which was highlighted as red meaning it needed to be refreshed. We observed staff supporting people to transfer into wheelchairs with no brakes on. This practice may have been due to a lack of training and competency.

We were given two documents that recorded supervisions; one was a matrix RAG report and another staff supervision matrix 2017. The RAG report identified training as red, amber or green to specify if it was out of date, in need of refreshing or in date. The matrix RAG report detailed that 45% of staff had not attended an annual appraisal, however the information on the staff supervision matrix 2017 was different so it was difficult to conclude whether people had received a timely appraisal or not. Appraisals are used to assess and develop the work of employees, alongside the attendance at more regular supervision meetings. Regular, effective supervision should result in positive outcomes for people, staff and the organisation. Each staff member had a named supervisor and the policy on supervision stated staff should be given the opportunity to attend a supervision meeting at least four times a year. We saw attendance was inconsistent over the year. Four staff had not attended any supervision meetings and six staff had attended one meeting this year. Only four of the 31 staff on the matrix had attended three supervisions this year and were on track to meet the provider's policy. This meant staff had not received the appropriate supervision and appraisal as is necessary to enable them to carry out their role.

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing

We spoke with staff and there was some understanding of mental capacity. One senior care worker told us capacity was, "Based on specific decisions to see if people can live within the home (mental capacity and best interest) same as care." Another said, "Capacity is around confidential information. Asking for help when some residents are independent and need prompting – sometime residents can get upset by this." All staff had attended MCA and DoLS training. Staff had also attended training in safeguarding adults at risk, dementia awareness, understanding and managing behaviour that challenges, bed rail safety and diet and nutrition.

We were told that one person on the first floor had been assessed by the speech and language therapy team as needing a soft diet due to the speed with which they ate placing them at risk. They then said, "[Person] did get a biscuit and I couldn't get it off them yesterday so I sat with them and they ate it." We asked if this had been reported to the manager and they said not.

There were no menus on tables or walls and no pictorial menus in either of the dining rooms so it was

unclear how people knew what the options were for their meal. People were offered leek and potato soup and a choice of cheese and tomato quiche with American coleslaw or sandwiches followed by banana sponge and custard. The food was nicely presented and looked nutritious. All the people we spoke with told us they had enjoyed their lunch.

On the ground floor the chef and a kitchen assistant served the meals whilst the chef and a care worker supported people to eat. One person asked us how she could eat the food on her plate as there was no care staff present to support her. The chef was very friendly and had a good rapport with diners; he also had a good knowledge of their needs.

As the chef was providing support to people on the ground floor this delayed the serving of lunch to the first floor dining room. We noted a staff member from the first floor came down to the ground floor dining room to enquire how long food would be. The chef responded with, "At least 12-15 minutes." People on the first floor were also supported by the chef, alongside the nurse and two care workers.

Nutritional assessments were in place which identified if people needed additional support with nutrition and hydration. Any uneaten food on people's plates was removed quite quickly. One person had only eaten a quarter of a sandwich and was asked if he had finished and wanted some sponge and custard. The person said they had finished and wanted pudding and the uneaten sandwiches were removed. There was no prompting or encouragement to eat more.

We also observed there were large uncovered jugs containing liquids stored in the fridge with a large carton of margarine resting on the top.

Morning refreshments included tea, coffee and juice with two biscuits, two strawberries and a piece of kiwi fruit. Afternoon refreshments included tea, coffee, juice and chocolate biscuits.

Care records evidenced that people had access to external health care professionals such as GPs, community nurses and district nurses.

There were a number of features within the home that supported people living with a dementia to orientate to their surroundings. These included a range of different coloured doors for people's bedrooms, toilets and shower rooms. Handrails were also painted a different colour to support people to identify them and use them for support. Toilet seats in ensuite rooms and shower rooms were coloured and toilet doors contained a picture of a toilet.

Memory boxes and the names and photographs of people were on their doors alongside room numbers. It was noted that some vacant rooms still had photographs and names on the doors.

Corridors were themed to stimulate discussion and reminiscence such as large poster pictures with cars, shop fronts, including a bakery, florist and betting shop, and a post office scene with mail box, letters and a telephone.

Carpets in the dining rooms were stained and walls and paintwork was chipped.

Requires Improvement

Is the service caring?

Our findings

We spoke with people and their relatives about the care provided at Paddock Stile Manor. We received mixed messages from people and relatives about the staff. Most people thought the staff were caring but, as stated in the safe domain, they commented that there were not enough of them which had an impact on people. One person told us, "The Staff are alright although I don't like the attitude of the [named staff member]. When I was at home I had 3 falls in the bath. I've been here 8 months and not had a bath. I just get a wash down." Two relatives commented to us their family members clothes had not been changed after lunch, one relative said, "[Family member] was scruffy." They added, "Their trousers were dirty." They said, "The girls apologised and said they didn't have time so I struggled to change him and it's difficult because it doesn't register when you ask him to lift his leg he just keeps it firmly on the ground. I also shave him because they don't have time. Other wives say the same." We raised these concerns with the manager who said, "No one has complained to me."

A relative said, "The girls are great but there is not enough staff. They're left to vegetate here (first floor lounge) they seem to do more with downstairs who can do more. It's gone flat since [named staff member] left. She used to come in full of life. They need stimulation. Sometimes there's music and they love it. They need more like that." Another relative said, "The staff are all good but there's not enough of them, they could do with more."

At the beginning of our inspection we enquired as to the number of people living on the first floor, a care worker told us 14 however we saw one person had passed away during the night. This meant a thorough handover had not been completed as day staff thought they were caring for 14 people when in fact that was incorrect. We also heard staff on the ground floor referring to people by their room number rather than their name. This was very evident during the handover during which we noted no one was referred to by name. We raised this with the regional manager and the manager. The regional manager said, "I'm really shocked about that, we need to address it."

We observed staff engagement on the ground floor. There were two care staff present with ten people. One staff member was administering people's medicines whilst another care worker was sitting completing documentation. There was no engagement from this care worker and when one person became distressed that they did not have their watch and couldn't find it the staff member failed to respond and turned towards the window to continue writing.

One staff member told us, "We have all the personal toiletry items locked in the store room so we have to go and find the nurse to get into the store room as she holds the keys and its locked at all times." Staff were unaware of the reasoning behind this and shared that it impacted on people's dignity as it could delay people receiving personal care. Care documentation did not include a risk assessment or a record indicating this process had been discussed with people.

The first floor had a small administration area in the small lounge. There was a 'bed changing notice' on the wall which detailed the day each room should have the bedding changed and that all dressing gowns were

laundered on a Friday. There was also access to bowel charts, daily communications and skin bundles which were on display in this area. This meant information was not being stored securely and anyone living at the home or visiting could readily read confidential, sensitive and personal information about people.

These concerns were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Dignity and respect

Family members confirmed they could visit anytime and that they were kept informed of any changes in the health of their family member.

Relatives told us they were involved in the care plan for their family member. There was limited evidence of this within care records, but one relative said, "Me, my brothers and sister are all involved, when we had a problem they listened and put in extra observations and it seems to have worked." A second relative said, "I've been involved from the start. I don't come to relative meetings because they're at night and I don't come out after 5pm." We saw comments from relatives with regards to the care provided however these were not signed by the relative and had been recorded by a staff member.

One person told us, "Staff are great, lovely," Another said, "It's very good here but I would rather be at home. A third person said, "They are lovely people, they do their best for you." A fourth person said, "It's all nice, the staff, the food, the other people."

Inadequate

Is the service responsive?

Our findings

During the last inspection we found a breach of regulation. Care plans had not always been written in relation to peoples assessed needs. For example, people living with epilepsy did not always have a documented care plan. Care plans did not always contain the necessary detail to support staff to provide safe care and treatment. Care plans in relation to positional changes and night time checks contained contradictory information and were not always followed.

The provider had submitted an action plan after the last inspection detailing how they would address the concerns however we found improvements had not been made.

We found care documentation continued to lack detailed information and strategies for staff to follow, we also found contradictory information had been recorded. This meant there was a continued failure to ensure service users received safe care and treatment. For example, one person's care plan stated they would often refuse a bath but there was no detail around the process to follow if the person refused.

Another person had a care plan for personal care and wellbeing which stated they needed the 'assistance and guidance of one carer to support them'. It stated, 'One carer to assist with washing and dressing and encouragement and prompting from staff.' Another of their care plans stated, 'Unable to bath independently and requires the assistance of one carer to ensure safety.' Neither care plan contained detail on the assistance or support that was needed.

Another person had a mental state and cognition care plan. This detailed the person's medicines and stated, 'Disorientated to time and place, can become distressed and agitated and needs constant reassurance of where she is and why'. It went on to state, 'Tends to become more agitated at a tea time, this is when staff may give ½ mg of lorazepam.' There were no triggers identified other than tea time for the persons increased anxiety, nor were they any strategies for staff to follow to reduce their distress before the administration of medicines. We saw lorazepam had been administered due to the person being, 'upset and weepy.' There were no detailed descriptors as to how the person would present when distressed or agitated so staff may not have been responding in a consistent manner. This meant medicines may have been unduly relied upon to support the person.

Another person's care plan stated, 'Diagnosis of dementia and moods can vary from time to time.' The descriptors used for this person's presentation included, 'bossy, and aggressive'. There was no detail in relation to any possible triggers for their distressed behaviour. We saw a behaviour chart which had been completed in relation to a person going into other people's rooms. It stated, 'Staff stood in front of [person] for 20 minutes.' There was no detail in the care plan in relation to distraction techniques, which meant staff had physically blocked the person from attempting to enter rooms, potentially leading to further distress and agitation. This meant staff did not have the appropriate knowledge to provide safe care and treatment for the person.

We observed one person who was sitting slumped in an arm chair. Their relatives visited and expressed

concerns about the person's presentation. Staff attended, took observations and said the person was fine. The manager said, "They are just tired." Later we observed the person was sliding out of the chair. We raised concerns with staff and one staff member attended. They went to fetch another staff member as the person did not respond to them. With two staff present the person became agitated, one staff member said, "I don't know what to do," so they left. There was no attempt, until inspectors intervened, to ensure this person was safe and in receipt of appropriate care and treatment. It was the regional manager who asked if the Doctor had been contacted. We raised this with the manager who did not comment.

Care plans in relation to mobility support were in place, however they lacked sufficient detail. For example one care plan identified that the person needed the support of two staff with mobility and transferring. However it did not detail what support was needed or whether any equipment was used such as a hoist. Another person's mobility care plan stated, 'Mobilises with a walking stick.' A risk assessment advised, 'Staff to encourage [person] to use walking stick.' We observed this person walked without the support of their walking stick a number of times during our inspection.

Night time checks had been recorded in advance, for example we saw staff have documented the completion of night time checks before the allocated time of the check. This meant we could not be sure staff were actually completing checks of people at appropriate intervals overnight. This placed people at risk of unsafe care as required health and safety checks were not completed in a timely manner.

We also found contradictory information was recorded in relation to Do Not Attempt Cardio Pulmonary Resuscitation orders (DNACPRs). For example, one person had a medicines profile which stated they had a DNACPR in place but their care records stated they did not want a DNACPR. The manager confirmed the person did not have a DNACPR in place. If staff followed the instructions on the medicine profile they would not, in an emergency, commence CPR however the person had expressed that they wanted to be resuscitated.

Given the high reliance on agency staff, especially nurses, and staff working at the home with no induction this meant there was inaccurate information for staff to follow which placed people at risk of receiving inappropriate care and treatment. Our observations were that staff did not know people sufficiently well to provide appropriate and safe care and treatment for people.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment

We asked people if their preferences were met. One person said, "I prefer to have girl carers but sometimes I get a man and I don't like it. I don't mind the man who sometimes does my blood pressure."

The activities co-ordinator told us they asked people what activities they would like to do and took a lead from people, they said they tried to do one-to-one activities such as Indian head massage and hand massage. They also said they took three people out each Tuesday morning to church for coffee and took people to the Living Room where older pupils at Newbottle School interacted with older people, played bingo and served refreshments. A taxi was used for trips out although there was access to a mini bus on a Wednesday. We were told that family members supported fundraising activities with prizes and gifts.

During the inspection we did not observe any activities on day one, on day two we observed people playing balloon tennis followed by nail painting. The hairdresser also visited on the second day and people were keen to have their hair done. We did not see any specific male oriented activities, or activities for people who were nursed in bed. This meant they may have been at increased risk of social isolation.

We asked a care worker if they knew about any activities for the day or if the activities co-ordinator was on shift. The carer did not know but thought the activities person had been in at the weekend and commented, "They're probably not in today." This was on the second day of inspection when the activities coordinator was present.

The notice board detailing daily activities was for the month of August. There was no acknowledgement that this may have been disorienting and confusing for people. The activities co-ordinator explained they were recruiting another activities person as one left the previous month.

We recommend the provider review current guidance on meaningful activities for people living with a dementia, for example NICE Quality Statements.

A complaints file was in place and recorded that two complaints had been made in March 2017 about staffing levels. The manager explained that they had gone through the dependency tool with the complainants and they were happy with the outcome. There was one current complaint which was being investigated. They went on to say, "I don't like the branches on the tree – they dance on my window when it's windy, I've told them but nothing happens."

Two relatives said they had provided feedback on services provided by Paddock Stile Manor but could not remember when. The third family member was not aware of providing any feedback and none of the people we spoke with could recall being asked to give feedback. The manager said they had arranged a resident and relatives meetings but no one had turned up so another one was to be arranged.

Inadequate

Is the service well-led?

Our findings

During the last inspection we found a breach of regulation. The quality assurance system had not been effective in identifying the concerns noted during the inspection.

Following the last inspection the provider submitted an action plan to the Commission which stated, 'Manager or deputy manager will conduct monthly audits of care plans to check that all risks have been identified, have an appropriate risk assessment in place and that referrals to outside professionals have been submitted where required. An action plan will be devised to identify any outstanding actions and this will be allocated to a member of staff to complete. The manager or deputy manager will re audit the care plan in 7 days to see that the actions have been completed. Head of Regional Operations will spot check care plans at their monthly visit.'

There was no evidence presented during this inspection to confirm this action had been completed. We found a sample of care files had been audited on a monthly basis however they had not been signed by the home manager, there was no review date and actions had not been signed off as complete. There was no evidence of the head of regional operations spot checking care plans each month.

We found continued evidence that systems and processes had not been fully established and operated effectively to ensure compliance with some regulations. We found shortfalls and deficits with record keeping. There was a failure to maintain accurate, complete and contemporaneous records in respect of each person which meant care staff were not provided with sufficient detail to ensure safe care was provided.

There were gaps, omissions and irregularities in the records related to medicines management, including the administration of 'as and when required' medicines and covert medicines. Medicines audits were not always fully completed, they did not always identify actions and whether they had been completed and they had not always been signed.

We found failings in relation to the accuracy of Personal Emergency Evacuation Plans, which were of an ongoing concern, as noted during the February 2017 inspection. Additional concerns included a failure to follow the provider's policy with regards to the completion of fire drills and a failure to ensure staff understood the procedures for the safe evacuation of service users.

During this inspection we also found night time checks had been completed in advance. The regional manager said, "We've implemented night time audits to prevent that so have put governance in place." However, the manager was unable to produce evidence of night time audits having been completed and the governance was not effective in ensuring this did not happen.

We spoke with the manager and regional manager about audits. The regional manager explained that audits had not been completed as it was part of the deputy manager's responsibilities to complete them. They told us, "The deputy manager had not been completing these." We asked for a copy of senior

management audits and were told this would not be completed until the end of the month. The regional manager explained that the Commission had instructed that they be based at one of the providers other locations. This meant they had been unable to complete an audit but had arranged for a quality monitoring audit to be completed by the interim compliance officer.

This had been completed on 21 August 2017. The regional manager said they were giving the manager time to complete the actions needed before completing a further audit. We noted the action points from the audit, including findings such as care plans not reflecting the current needs of people, had not generated an action plan. There was no evidence that any actions had been implemented. The manager and the regional manager were unable to provide any additional senior manager audits, nor were there any audits completed by the manager. The manager said, "I agree there are areas to improve."

The provider's staff supervision policy referred to Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These Regulations have since been updated so the provider had failed to ensure its policy was up to date with current legislation.

These findings were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance

The current manager had started working at Paddock Stile Manor in March 2017. Their registered manager application to the commission had not been fully submitted until August 2017. This meant the home had been without a registered manager for eight months. The manager told us, "I was the training executive previously but always wanted to manage a care home. It's the ethos of the company to develop staff. [Regional manager] and [registered manager at a different location] are great, really supportive."

We saw regular staff meetings had taken place and included discussions around, 'a lack of structure in care plans' and in July it had been noted that clinical audits needed to be completed monthly and there were lots of improvements needed to daily communication. We saw audits had been completed in relation to weight loss, skin tears and infection monitoring however there was no analysis or lessons learnt. The regional manager explained the provider was moving towards an electronic system of recording which would help with analysis and look at patterns.

Most of the staff, people and staff we spoke with said they thought Paddock Stile Manor was well managed. Although one person commented, "I don't like the attitude of the man manager."