Interhaze Limited

# Wheatsheaf Court Care Home

## Inspection report

44 Sheaf Street
Daventry
Northamptonshire
NN11 4AB

Tel: 01327705611
Website: www.interhaze.co.uk

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This unannounced inspection took place over two days on 27 and 28 November 2018. The first day of the inspection was unannounced, we carried out an announced visit on the second day.

Wheatsheaf Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Wheatsheaf Court Care Home is registered to provide accommodation, nursing and personal care to up to 55 people in one adapted building. At the time of the inspection there were 34 people living in the home.

There was a registered manager in post. 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.

At the previous comprehensive inspection on 18, 19 and 20 September 2017, the service was rated 'Requires Improvement'.

Systems and processes in place to assess, monitor and improve the quality and safety of the service were not always effective at identifying concerns. Areas of the home were not well maintained or clean. The impact on people of ongoing refurbishment in the home had not been adequately assessed.

Where shortfalls were identified these were not always addressed in a sufficiently timely manner. People did not always receive their care from staff who knew them well as there was a high reliance on agency staff. This also affected the amount of social interaction and activity available to people.

People were not consistently involved in planning their care and the systems in place for responding to people's feedback required strengthening. Improvements were required to ensure people received their medicines as prescribed.

The provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements in relation to the safety, maintenance, cleanliness and governance of the service. The provider submitted an action plan detailing the improvements that they would make to comply with the regulations.

At this comprehensive inspection, we have found that the required improvements have not been made. 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 suitability and safety of the environment needs to be addressed to ensure that the environment people live in is appropriate and safe. Risks posed by the environment have not been identified or acted upon in a timely manner and as a result have not been resolved. Where risks have been identified insufficient action has been taken to mitigate these risks. We have found that many areas of the environment are dirty and unhygienic and the principles of infection control are not consistently adhered to.

The deployment of staff is inconsistent due to a lack of permanent staff recruited and use of agency staff. People have experienced and are at risk of experiencing care that does not meet their needs as a result.

There is a lack of care delivered to meet people's individual needs and maintain their dignity.

People's dignity is not being maintained at the service. People's personal care is not being provided in the way they wish and some people are in an unkempt state.

We have received some feedback that staff do not always communicate with people in a kind or respectful manner. This raises concerns that people have been subject to abuse and safeguarding referrals have been made as a result.

People's personal preferences in relation to their care is not always considered and people lack stimulation and choices about how they spend their time.

People are not provided with an appetising choice of food. We have been told that the food served at mealtimes is often cold and of poor quality.

People do not feel listened to by the provider, as they have raised concerns about the service they receive but no action has been taken.

There is a lack of effective monitoring in place at the service and this has resulted in poor outcomes for people using the service. Ineffective quality monitoring systems have failed to pick up and address the failings we identified during our inspection.

We found individual staff to be caring and compassionate towards people, however, due to staffing deployment at the service they lack time to be able to spend with people. Care being delivered is often task focussed.

Staff are provided with appropriate training and support; however, do not always put the training they have received into practice.

Medicines are safely managed; regular audits are in place and medicines records are completed accurately.

People are supported to maintain good health. Staff have the knowledge and skills to support them and there is prompt access to healthcare services when needed. People's nutritional needs are assessed and monitored.

The principles of the Mental Capacity Act 2005 are followed at the service and people have assessments and best interest decisions documented when needed.

At this inspection we have found breaches of six regulations of the Health and Social Care Act 2008 Activities) Regulations 2014. Full details regarding the actions we have taken are added to reports after any representations or 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.

People were not protected from environmental and infection risks, as measures in place to identify and reduce these risks were not sufficient.

Staffing deployment was inconsistent, which put people at risk of unsafe care and support.

Medicines were managed safely and people could be assured that they would receive their prescribed medicines.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were not provided with food and drink that met their choices and preferences.

Staff received appropriate training, but did not always put this training into practice. Staff had access to regular supervision.

People were supported to access relevant health and social care professionals to ensure they received the care and treatment that they needed.

The principles of the Mental Capacity Act (MCA) 2005 had been applied appropriately.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People's dignity was not maintained, staff did not always speak to people appropriately.

People's support was task focussed and staff lacked time to spend with people.

People were supported to be involved in decisions about their care.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People were not provided with sufficient social interaction and activity.

People's care plans contained detailed information and were reviewed with them on a periodic basis.

A complaints policy was in place and information available to raise concerns. People knew how to complain if they needed to.

## Is the service well-led?

**Inadequate**

The service was not well led.

Appropriate systems to monitor the quality of care that people received had not been implemented.

Areas identified at the previous inspection in relation to the governance of the service had not been resolved by the provider.

The provider had not deployed appropriate strategies to address previous breaches of regulation to drive continuous improvement.

A registered manager was in post and people and staff were positive about their role in the home.

# Wheatsheaf Court Care 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 comprehensive inspection took place on the 27 and 28 November 2018 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor, and an expert by experience. A specialist advisor is a person with professional expertise in care and nursing. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of co-ordinating care services for relatives.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us; a statutory notification is information about important events that the provider is required to send us by law. We reviewed information sent to us by other agencies, including the local authority and clinical commissioning group, who commission services from the provider. We also requested information from Healthwatch; an independent consumer champion for people who use health and social care services.

During our inspection, we spoke with six people who lived in the home, five people's relatives and with the permission of one person; their friend who was visiting. We also observed the care and support being provided to people.

We spoke with the registered manager, clinical lead and nine members of staff including care staff, nursing staff, catering staff and domestic staff. We looked at four records relating to people's care needs and four staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, quality surveys, training information for staff and arrangements in place for managing complaints.

Inadequate

# Is the service safe?

## Our findings

At the last inspection in September 2017, we rated 'Safe' as 'Requires Improvement and the provider was in breach of Regulation 12 (1) Safe care and treatment. We asked the provider to take action to make improvements in relation to the safety of the environment. The provider submitted an action plan detailing the improvements that they would make to comply with the regulations. They stated that they would be compliant by 6 February 2018.

At this inspection, we found that the provider had not taken sufficient action to meet the breach in regulation and comply with the action plan. The provider continues to be in breach of Regulation 12 (1). This is because they have continued to fail to identify and address serious risks to people's health and wellbeing. This ongoing failure has contributed towards the rating of 'Inadequate' in the 'Safe' domain.

During the inspection we found that people were not protected from risks associated with an unsafe, poorly maintained, unhygienic environment. For example, people were not protected from the risk of burns. We found that the water coming from the tap in the staff toilet was extremely hot and posed a risk of scalding to people. We raised this with the registered manager, and were told that the key pad on the door should be used to secure this area. During the inspection we found that the door was open on several occasions. This room was next to the lounge on the ground floor, vulnerable people with dementia were using this area, some of whom were able to walk independently. We found several radiators with no covers, some of these radiators were extremely hot. The failure to provide a safe environment put people at risk of scalding and burns.

Different flooring between bedrooms and ensuite bathrooms and corridors and bedrooms had not been joined properly and as a result the flooring was lifting, posing a trip hazard. We saw that wiring that should have been enclosed was exposed. For example, a nurse call system box in a person's bedroom had not been fitted correctly and the wires that should have been enclosed in the call system box could be seen. The service provides care to people with dementia, some of whom move around the home independently, this unsecured wiring posed a risk to their health and wellbeing. In one person's ensuite bathroom, a loose nail was protruding from the wood next to the toilet. There was a risk that the person could have been injured by the nail when using the ensuite.

On the morning of the second day of inspection, whilst touring the building with the registered manager, the inspector slipped on debris that had been left on the floor of a corridor after maintenance staff had sealed areas of flooring. As the tour continued similar items were picked up from the floor of the corridor by the inspector and registered manager to prevent other people from slipping. Some people walked independently; this presented a risk of people slipping on these items and sustaining injury.

The environmental risk assessments in place had not identified the risks posed to people by the ongoing refurbishment of the home. The refurbishment had begun before the last inspection in September 2017, the lack of environmental risk assessments in place to identify the risks posed to people was identified at that inspection. A significant amount of refurbishment, decoration and maintenance work continued to be

undertaken in areas accessed by people, such as corridors. Sufficient risk assessments had not been carried out regarding this work and no plans were in place to mitigate the risks posed to people's health and safety.

The environment and lack of cleaning being undertaken put people at risk of infection. For example, toilet brushes and holders were extremely soiled and worn; these were not being regularly cleaned, checked or replaced. Toilet roll that was out for people to use was marked with what looked like faecal matter. In the communal toilet on the first floor, tiles were missing from the wall behind the toilet, faeces was smeared over the seat which was also stained with urine and there was no hand towel available. The flooring behind the toilet was damaged and had a build-up of dust and dirt.

Staff did not consistently work in a safe way. For example, staff shared equipment between people which posed a risk that infection could be transmitted. People who required hoisting had an allocated hoist sling and slide sheet where this was required for their care. However, we saw that if these were in the laundry, staff borrowed from other people and then returned after use without cleaning. We observed two staff supporting a person to reposition. They stated that the person's slide sheet was not in their room so they would borrow from another person whose room was nearby. We saw staff use the other person's slide sheet that had been taken from their room to reposition the person in bed. Staff were not following safe hygiene practices in relation to laundry and equipment which put people at risk of infection.

People could not be assured that staff would act promptly to report concerns regarding the safety and suitability of equipment. For example, one person had a moisture lesion on their sacrum. They were being cared for in bed and were on an electric pressure relieving mattress to reduce the risk of this area deteriorating and to minimise the risk of pressure ulcers. During the inspection we found that the pump to inflate the mattress had been switched off and the mattress was deflating. The registered manager switched the pump on but it did not work. Discussions with staff and a review of records identified that this had been switched off in the previous two hours. Staff had not reported the broken pump to senior staff. The person was unwell, very frail and at high risk of skin damage.

Measures in place to manage the use of thickening agents that were added to people's drinks to ensure they were able to swallow them safely were not effective. We saw containers of thickener prescribed for people did not have labels attached to show who they were prescribed for or directions for administration. Staff told us that they would use the containers with no label as they knew how much thickener people required. Staff were relying on their memory to administer a prescribed product. The service often used care and nursing staff supplied by an agency, there was an additional risk that these staff would not know how much thickener to add due to the lack of instructions on the container. There was a risk that service users would be provided with drinks that were the wrong consistency placing them at risk of aspiration.

Although personal emergency evacuation plans (PEEPS) were in place for people these were held electronically. There was no emergency grab bag or provision for information to be given to emergency services in the event that the home had to be evacuated. There was no procedure in place to ensure that the information held electronically would be accessible to advise emergency service staff of the support that people in different areas of the home required.

This was an ongoing breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in September 2017, the provider was in breach of Regulation 15 (1) premises and equipment. We asked the provider to take action to make improvements in relation to the cleanliness and maintenance of the environment. The provider submitted an action plan detailing the improvements that

they would make to comply with the regulations. They stated that they had made immediate improvements and this work was ongoing.

At this inspection, we found that the provider had not taken sufficient action to meet the breach in regulation. The provider continues to be in breach of Regulation 15 (1). This is because they have continued to fail to ensure that the environment in which people are living is well maintained and clean. This ongoing failure has contributed towards the rating of 'Inadequate' in the 'Safe' domain.

Refurbishment had been ongoing since before the previous inspection, however insufficient progress had been made and the environment continued to be poorly maintained and dirty. Throughout the home we saw walls and doors in many areas where spillages had dried on the walls but these had not been cleaned. Walls in people's bedrooms and ensuites were stained and dirty. Sinks in people's ensuites were dusty and dirty. Extractor fans in people's ensuites were consistently seen to be full of dust and dirt.

Carpeted areas were covered in a build-up of bits and dirt. We saw that all carpeted staircases had a significant build-up of dust and dirt. We addressed this with the registered manager, who told us the mess was due to the maintenance work. One staircase that was covered in vinyl type flooring was sticky under foot both days of the inspection and had visible marks where something had been spilled on the floor. There was insufficient cleaning in place to ensure the environment people were living in was clean.

Equipment that was being used by people was not well maintained and was dirty. For example, hoists and wheelchairs that were stored in the downstairs storage area ready for use were extremely dirty. Chairs in lounge areas that people were sitting in had rips and holes in where the stuffing was coming out, making them impossible to clean properly.

Walls and fittings in corridors, ensuite bathrooms and storage areas continued to be poorly maintained, with bare plaster and cracks exposed. We found several electrical installations that were without their covers, for example where new lighting had been fitted in corridors no covers had been put in place. Areas that had been refurbished had not been completed to a high enough standard, we saw areas of flooring in corridors that the registered manager said had been completed but flooring did not reach the skirting board. The main shower room which had been refurbished was used as storage. This room was accessible to people; however, it was cluttered with equipment, making it difficult for service users to use.

This was an ongoing breach of Regulation 15 (1) premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that there were sufficient numbers of care staff on duty, however high levels of agency staff impacted on people's experiences of the care and support provided. At this inspection we found that improvements continued to be required to staff deployment and people told us they often had to wait for care. One person said, "I do ring my buzzer but there is a terrible wait sometimes." Another person said, "There is always a wait when you ring for any kind of help, they are always short on staff."

People and staff told us that people's experience of care was affected by the number and mix of permanent and agency staff on duty and that this was noticeable at weekends. One person said, "They are always short staffed, the weekend is worse, you're lucky if you get your bed made on Saturdays." Staff told us that more agency staff were used at weekends and this affected the consistency of care they were able to provide. One member of staff said, "Staffing depends on the day, depends on the person you are working with. If it is agency [staff] who don't know the floor you have to do everything yourself…weekends are worse." Another member of staff told us that every other weekend was difficult because the agency staff working were new

and didn't know the home, they said, "Everything takes twice as long."

Rotas that we reviewed reflected what we had been told by people and staff about the numbers of agency staff deployed in the home.

There were insufficient domestic staff to maintain the cleanliness of the home; staff had left and were on holiday but insufficient arrangements had been made to cover their duties. Domestic staff were deployed to make people's beds; however, we saw that beds were not made until very late in the day when care staff supported people to go to bed. For example, we saw that one person's bed was dirty, had crumbs on the bottom sheet and was unmade at six o'clock in the evening. Care staff brought the person into the room to go to bed and explained that they were changing the bed now as they did not have time earlier in the day.

The registered manager was actively recruiting new care and domestic staff and two new care staff were on their induction during the inspection. However, staff had not been recruited quickly enough to minimise the impact on people's experience of care.

This was a breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in September 2017, we found that people's medicines were not always safely managed. At this inspection we found that people received their medicines in a safe way and as prescribed by their GP. One person told us, "I am on medication, I have [medical condition], they give me everything on time." Medicines were administered by trained nursing staff and care practitioners who had received appropriate training. Information on the support people needed to take their medicines was included in their plan of care. Records showed that medicine stocks were regularly checked to make sure they were correct and in line with the medicine administration records. Audits were carried out on a monthly basis to make sure records were up to date and the support people needed was provided.

During our inspection, people disclosed allegations of abuse to members of the inspection team and safeguarding referrals were made as a result. People were not consistently protected from the risk of abuse as the registered manager was not aware of all incidents that occurred at the service where people were at risk of harm. We saw that staff had received training in this area and information regarding safeguarding was available. Where the registered manager was aware of safeguarding incidents, they had submitted safeguarding alerts to the local safeguarding team and had worked with the local authority in completing investigations as required.

Incidents and accidents that had occurred within the service were recorded. These had been reviewed by the registered manager and action taken as necessary. Through staff meetings and supervision, any concerns were shared within the staff team to enable learning and improve practice. Records were updated to reflect any changes in people's needs to enable staff to provide people with safe care.

Safe recruitment procedures were carried out by the service. We looked at staff files which showed that all staff employed had a criminal record check, and had provided references and identification before starting work.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection in September 2017, we rated 'Effective' as 'Requires Improvement', at this inspection 'Effective' continues to be rated as 'Requires Improvement'.

People could not be assured that they would be provided with a choice of appetising food at meal times. Food was prepared remotely, delivered to the home via chilled transport and then re-heated for meals. The majority of people told us the food was of poor quality, cold and they were not asked what food they would like to eat. One person said, "The food is awful, you will see in a minute, stale cake and cold custard." Another person said, "The food is rubbish, it's never warm, that mince I have just eaten was horrible and if you're a slow eater like me you can imagine how cold it's going to be by the time I have finished."

Menus were displayed in the dining room; however, people could not see these and staff assumed that they knew what people wanted and gave them this. One person said, "The food is terrible sometimes, we don't normally have a choice, they are doing that you know, coming around asking us what we want because you're here." People were not offered choice of where to eat their meal, some people were left in the lounge areas to eat from individual tables and were unaware that they could choose to sit anywhere else.

People told us that the food was cold when it was served to them. One person said, "The food I would say is reasonable, I can't say it's good because it's not and it's always cold when it gets to me…I have never been asked what I would like, I just eat what is given to me, for some reason they asked me today." The food was sent down from the kitchen in a heated trolley but was then transported to the other areas by staff, meaning that when it reached some people it was cold.

We observed staff supporting one person to eat a soft diet and asked them what the meal was, they didn't know and had not told the person what they were eating. We observed lunch service in the dining room and three staff were supporting two people each with their meal. This meant that people were left with long gaps between being supported and their food would have gone cold. People did not receive individual one to one attention from staff whilst they ate their meal.

This was a breach of Regulation 9 (1) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST) and referred people to their GP and dietitian when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have sufficient amounts of food and drink. People's care plans contained detailed instructions about people's individual dietary needs, for example, if people required a modified diet this was recorded.

Improvements were required to ensure the environment met people's needs. The service supports people living with dementia; however due to the high levels of refurbishment that were on going in some areas there was insufficient signage or pictorial information to support people to find their way or provide people

with information. There was an accessible courtyard, this was in need of tidying and renovating to make it a pleasant space for people to use. However, some people had been supported to personalise their bedrooms and the lounges had been refurbished. One person's relative said, "They [registered manager] have been very good about [family member's] room, whatever they wanted they could bring, they've even got their [item of furniture from home]."

People could not be assured that their needs would consistently be met by staff who acted with appropriate knowledge and skills when providing their care. Staff had received training that was relevant to their role, however staff did not always put this training into practice. Staff had received training in infection prevention and control but this had not been effective in ensuring people's needs were met in a safe way.

Staff told us that they were encouraged to attend training and that additional training was supplied when requested. One member of staff said, "I've just started a leadership course, it's really good because all the [staff's roles] are doing it together so we can talk about what we're learning." Records showed that one member of staff had requested additional training in dementia and this had been provided. Staff had accessed training in key areas such as health and safety, mental capacity and safeguarding on a regular basis. Nursing staff were supported to access training appropriate to their role including wound care, emergency first aid and syringe drivers. A syringe driver is a small battery-powered pump that delivers medication at a constant rate through a very fine needle under the skin.

At the last inspection we found that although staff had access to regular support and supervision, this had not been effective in enabling them to raise their concerns. At this inspection, staff told us they received regular supervision from senior staff and the registered manager. Staff said that they felt supported and that supervision gave them the opportunity to discuss any concerns and receive feedback about their performance. Supervision meetings were used to assess staff performance and identify on-going support and training needs. However, they had not been effective at identifying some of the concerns we observed with staff practice.

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The registered manager was aware of their responsibilities under the MCA and the DoLS Code of Practice. We saw that DoLS applications had been made for people who had restrictions made on their freedom. Best interest decisions were recorded in care plans where people were unable to consent to their care. However, the involvement of others such as relatives or the person's doctor was not consistently recorded. This was discussed with nursing staff who recognised the need for this involvement to be reflected. Choices and preferences were clear in people's care plans including where people had varied capacity. People told us that staff asked for their consent before carrying out any care.

People's needs and choices were assessed before they came to the service to help ensure it was suitable for them. People's relatives gave positive feedback about the assessment their family member had received. One person's relative said, "We met [registered manager] at the hospital and we went through an assessment." Records showed that peoples' needs were assessed, including their communication needs,

culture and faith and medical needs, so staff were aware of these as soon as they began using the service.

The service worked and communicated with other agencies and staff to facilitate a co-ordinated approach to people's care needs. We saw that people had input from a variety of professionals to monitor and contribute to their on-going support. People had ongoing support from a range of health and social care professionals to ensure they received appropriate care.

People's healthcare needs were monitored and prompt referrals were made when people's health needs changed. One person said, "You can see a doctor whenever you like." Another person told us, "I have just come back from the dentist, a [gender] carer took me, they are good like that if you have to go anywhere."

Requires Improvement

# Is the service caring?

## Our findings

At the last inspection in September 2017, we rated 'Caring' as 'Requires Improvement', at this inspection 'Caring' continues to be rated as 'Requires Improvement'.

People's experience of care was affected by the way staff provided their care and the way some staff interacted with them. We received feedback from two people that staff did not always communicate with them in a kind or respectful manner and that staff had shouted at them. We raised safeguarding referrals in response to the feedback and discussed the comments with the registered manager. Following discussions with people about how staff spoke to and treated them, the registered manager raised further safeguarding referrals.

We found evidence that people were not having showers or baths as often as they wished. One person told us, "I get washed over there [pointed to ensuite]. I don't get a bath or shower, I don't remember having one." Another person said, "I have a wash in the mornings, no I don't have a bath or shower, just a wash, they will bath you when they are not busy." A third person said, "I have a wash in the mornings, I think I have only had about three showers in a year." Records of baths and showers offered or provided to people were inconsistent and showed that some people did not have baths or showers very often. There was no process in place to monitor how often people were offered or supported to have a bath or shower.

Some people's relatives raised concerns about the personal care that was provided to their family member. One person's relative said, "[Family member's] hygiene is not brilliant, take a look at their finger nails, I will have to cut them for [family member]." We saw that the person had long dirty fingernails. Another person's relative said, "[Family member] could do with their hair washing now and again and their finger nails get long and dirty."

Our observations confirmed that people's dignity was not sufficiently maintained as people were left in an unkempt state. For example, we saw that one person had spilled their breakfast on their clothing, they sat in the lounge all day wearing the same clothing. We asked staff why the person had not been supported to change their clothing but they were unable to tell us.

One person smelt of urine and their top was stained, when questioned the registered manager stated that they always smelt of urine, even though they believed that they were supported to wash. The registered manager had not considered the need to explore this further.

We saw one person shouting that they wanted to go to the toilet. They were swearing and shouting in the lounge for fifteen minutes and this had an impact on their and other people's wellbeing. We spoke to care staff who said that this was a known behaviour for the person and they had been assisted to the toilet already. Staff continually told the person that they would support them to toilet in a minute, this response made the person shout and swear more. Other than keep promising that staff would take the person to the toilet when they had finished getting people up staff did not know how to reassure the person. When we asked staff what they thought the reason for the person's behaviour was they said that it was because the

person had dementia. Staff did not know how to provide the person with appropriate care that supported their dignity.

This is a breach of Regulation 10(1) dignity and respect of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were involved as much as they were able to be in making decisions about their care. People and their relatives when appropriate were invited to be involved in review meetings to monitor that the care provided met their expectations and wishes. Care plans identified what was important to people so staff could support them to make decisions about what they wanted to do. We saw records that reflected people and relatives' involvement in deciding how their support would be provided. For example, how their pressure area care needs would be met.

People told us that staff respected their privacy and personal space. One person said, "Staff do knock on my door." Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information without people's consent. Records were stored appropriately and people's confidential information was treated appropriately by staff.

People told us that they received a basic level of care from staff. Comments from people included, "Most of them are caring, let's say they do their job but nothing out of the ordinary." Another person said, "They [staff] are ok, they are not over friendly, they do their job." Some people's relatives felt that their family members had good relationships with staff. One person's relative said, "Everyone [staff] is jolly, laughing and chatting, you get a good feel. [Family member] gets good care from good people."

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection in September 2018, we rated 'Responsive' as 'Requires Improvement', at this inspection 'Responsive' continues to be rated 'Requires Improvement'.

People told us that they enjoyed the activities that were provided and we received positive feedback about the activity staff, however some people said there was not enough to do. Comments included, "There's not much entertainment, it does get boring sat in here all day." And "I can't join in anything unless it was a quiz for me to answer and I like the music when that's put on for us, otherwise we just fall asleep with boredom."

The activity staff were on leave during the inspection and no contingency arrangements had been made to meet people's social needs. One person said, "[Activity staff] will get us to play bingo, I like to play that, [Activity staff] is very nice, sometimes we have music on, otherwise there's nothing to do. [Activity staff] is off this week, we did go outside in the nice weather and had ice cream but that's about it." We saw no activity happen during the inspection as care staff were focussed on care based tasks.

We saw that people spent long periods with little interaction with staff, at times staff were grouped around a table in the lounges chatting to one another, rather than engaging with people who lived in the home. One person said, "We always sit here with our tables, the [staff] when they pass by you will say "hello [person's name]" but they don't sit with us."

People's care plans contained detailed information about people's support needs. We saw that when staff were working with people to provide their personal care support they provided this in the way that people chose. We observed staff checking with people that they were happy with the way they were supporting them. Care plans contained information about all aspects of people's physical, emotional and social needs.

Permanent staff knew people well and were able to tell us people's individual routines, likes and dislikes, past occupations, hobbies and interests. We observed staff interacting with people on an individual basis in a person-centred way.

People were involved in their care planning and reviews of their care needs. The reviews provided updated information about people's needs and preferences.

People and their relatives told us they knew how to make a complaint or raise a concern. One person's relative said, "I haven't needed to make a complaint but feel confident that the manager would deal with it if I did." We saw that there were procedures in place to deal with complaints effectively and records of complaints received and investigations were fully completed.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded bodies to ensure people with a disability or sensory loss can access and understand

information they are given. Care plans contained detailed information regarding people's communication needs. The registered manager explained that information would be provided in different formats if this was required, for example large print.

People were supported at the end of their life to have a comfortable and pain-free death. No one currently living at the home was receiving end of life care but records showed people had been involved in discussions about the end of their life. An end of life care plan had been developed and it was recorded how people wished to be supported at this stage of their life.

Inadequate

# Is the service well-led?

## Our findings

At the last inspection in September 2018, we rated 'Well led' as 'Requires Improvement' and the provider was in breach of Regulation 17 (1) good governance. We asked the provider to take action to make improvements in relation to the governance and oversight of the service. The provider submitted an action plan detailing the improvements that they would make to comply with the regulations. They stated that they had made immediate improvements and these would be ongoing.

At this inspection, we found that the provider had not taken sufficient action to meet the breach in regulation and comply with the action plan. The provider continues to be in breach of Regulation 17 (1). This is because they have continued to fail to take sufficient action to effectively monitor and improve the quality of care and support people receive. This ongoing failure in the leadership and governance of the service has contributed towards the rating of 'Inadequate' in the 'Well-led' domain.

The systems in place to monitor the quality and cleanliness of the environment and infection control had not resulted in a safe environment where infection control risks were adequately managed. Significant concerns had been identified regarding the safety and suitability of the environment at the previous inspection in September 2017. However, the provider had failed to take sufficient action to meet the previous breaches in regulations and ensure that people were living in a safe, well maintained, hygienic home.

The provider had failed to deploy a system of audits to sufficiently assess the cleanliness, maintenance and suitability of the environment. Audits in place to measure and drive improvement were not detailed or effective and required improvement. Environmental audits did not reflect the actual condition of the service; This put people's health and safety at risk.

During an environmental audit carried out on 07 September 2018, the registered manager inspected forty bedrooms and thirteen other areas. Comments included, 'Refurbishment plan in place' and 'Refurbishment going well, four bedrooms left on ground floor for refurbishment.' The audit did not identify the continuing poor state of repair of many areas of the building, or identify what action would be taken to rectify these areas. The refurbishment action plan that was in place did not address in detail the work that continued to be required to improve the environment to a suitable standard for people to live in or identify the timescale for the completion of the work required.

An infection control audit completed by the registered manager on 05 November 2018 did not identify the unclean, unhygienic condition of the home, or the infection risks posed by the poorly maintained building.

The provider had failed to ensure that health and safety records were completed in line with their policies and procedures. Records showed that the running of water in ensuite bathrooms of bedrooms that were not in use, to prevent build-up of legionella bacteria had not been completed since the 08 November 2018. Legionella prevention procedures directed that this should be undertaken weekly. There was a risk of contamination and creating the conditions that encourage the growth of legionella. The registered manager

agreed that these had not been completed and stated that this was due to a lack of domestic staff.

The provider had failed to identify or take appropriate action in respect of thickener that was prescribed for people. Audits had not identified that individual containers of thickener were not labelled with service user's names or the instructions for use. Although an audit of the mealtime experience took place. this had failed to identify the poor quality of the food, that people were not offered choice and staff shortages at mealtimes.

The provider had failed to ensure that an effective system was in place to ensure people received safe support in an emergency. Although people had personal emergency evacuation plans in place there was no process in place to ensure that information was available to emergency services should the home need to be evacuated.

The provider had not taken sufficient action in response to feedback from people and their relatives. One person said, "I do go to meetings, I brought up about the food and the call bells not being answered, the manager said she will look into it. She told us she was going to have the courtyard covered over, but that's not as important as seeing to other problems first like the staff and a little bit of entertainment."

We saw that a service users' satisfaction survey was carried out in June 2018 and resident and relatives' meetings were carried out on 05 March 2018 and 08 August 2018. The feedback provided identified areas for improvement, which included; missing laundry, cold food at mealtimes, staff attention to personal hygiene and personal care needs, lack of staff availability and staff professionalism. No action plan had been put in place to demonstrate how the provider was going to use the feedback to drive improvement of the service. Some concerns had been raised more than once, for example missing laundry was raised at the service user and relatives' meeting on the 05 March 2018 and again on the 08 August 2018.

Staffing levels weren't assessed or monitored to ensure people's safety. Although a dependency tool was in place, this was not effective at identifying the inconsistencies in the way staff were deployed and the impact of high levels of agency staff. Staff were unable to deliver consistent, appropriate care and support due to the staffing deployment, however, this had not been identified as an issue.

During our inspection people told us about incidents that had impacted on their well-being and had a detrimental effect on their experience of the service. The registered manager was not aware of these incidents; which involved a lack of adequate care and support to people who used the service. There was a lack of effective oversight in relation to staff performance and the safety and quality of care being delivered.

The system of governance in place and a lack of effective quality monitoring had resulted in poor outcomes for people living at the service.

We saw that regular staff meetings were held covering a variety of topics such as staff working practice, the standard of people's personal care and health and safety. The registered manager had tried to address the failings in the service. However, the discussions that took place during these meetings had not resulted in the improvements that were required to people's care.

Although the provider had a number of quality assurance processes in place at the service, these had not been effective in identifying the number of widespread and significant shortfalls in safety and quality. Where issues had been identified they had failed to make improvements. These failings posed serious risks to people using the service. The oversight in place had not been effective.

This is an on-going breach of Regulation 17 (1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff we spoke with knew who the registered manager was and were positive about the registered manager; they described being able to approach them should they need to. One person said, "The manager seems very approachable if I need to say anything." Another person's relative said. "[Registered manager] is really open and honest, I feel I can ask anything, say anything." Staff told us, "The manager listens to us" and "We're very well supported by the manager, if we are short of staff due to sickness she will support people."

We found that where the registered manager had been aware of the incidents which needed to be notified to CQC and other agencies such as the safeguarding team, they had done so. However, we were not assured that all incidents which had taken place at the service had been notified to us due to the lack of management oversight we found at the service.

The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating as required.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People's care needs were not met in a way that met their choices and needs. People were not given choices about the food they would eat and told us that the food was poor quality. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not provided with care that supported and maintained their dignity. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>People could not be assured that the arrangements in place for staff deployment would provide staff at the agreed time to meet their assessed needs. |

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 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The provider had failed to ensure that the environment people lived in was safe. Risks posed by the environment had not been identified or acted upon in a timely manner and as a result had not been resolved. Where risks had been identified insufficient action had been taken to mitigate these risks. We found that many areas of the environment were dirty and unhygienic and the principles of infection control were not consistently adhered to. People's needs were not met in a safe way by staff. |

**The enforcement action we took:**

Imposed positive conditions on the provider's registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment |
| Treatment of disease, disorder or injury | Insufficient progress had been made in the refurbishment and maintenance of the environment and the environment continued to be poorly maintained and dirty. |

**The enforcement action we took:**

Imposed positive conditions on the provider's registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Appropriate systems to monitor the quality of care that people received had not been implemented.<br><br>Areas identified at the previous inspection in relation to the governance of the service had not been resolved by the provider. |

The provider had not deployed appropriate strategies to address previous breaches of regulation to drive continuous improvement.

**The enforcement action we took:**

Imposed positive conditions on the provider's registration