Barchester Healthcare Homes Limited

Tennyson Wharf

Inspection report

Park Lane
Burton Waters
Lincoln
Lincolnshire
LN1 2ZD

Tel: 01522848747
Website: www.barchester.com

Date of inspection visit:
23 January 2019
24 January 2019
11 February 2019

Date of publication:
28 May 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23, 24 January and 11 February 2019 and was unannounced.

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

Tennyson Wharf can accommodate 60 people in one adapted building across three floors. At the time of the inspection 51 people were resident, some of whom were living with a dementia.

The service had a registered manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last comprehensive inspection in January 2017 we rated the service as 'Requires Improvement' overall. We found the service did not consistently act in accordance with the Mental Capacity Act 2005 (MCA) and as required medicines (PRN) protocols were not consistently in place.

At this inspection we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe care, need for consent and treatment and good governance. You can see what action we have asked the home to take at the end of this report.

Medicines were not always administered in a safe manner and in accordance with NICE (National Institute for Health and Care Excellence) guidance and the provider's own policy. People did not always have their care needs met. Some people required repositioning to prevent skin deterioration and other people needed their fluids monitoring due to the risk of dehydration. People did not always receive safety checks and observations when they needed them. The service did not ensure people received the planned support which placed people at risk of harm.

The service was still not acting in accordance with the Mental Capacity Act 2005 (MCA). The service had a range of audits in place but these failed to identify the issues we found during this inspection. Where issues had been identified, actions plans were produced however these were not always completed as required.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not always support this practice.

Risks were not always identified and mitigated against.

The provider used a dependency tool to calculate staffing levels. People and relatives gave mixed views when we asked if there were enough staff to support people. We observed a number of times, staff were supporting people in their rooms leaving other people unattended. Personal emergency evacuation plans (PEEP) did not accurately reflect the staffing support people needed during an evacuation.

The service supported people to gain access to healthcare professionals.

People were complimentary about the meals provided. People were encouraged to be healthy and a balanced diet was promoted.

Staff treated people with respect and dignity. Staff were knowledgeable about people, their preferences, interests and people important to them. Staff supported people to be involved in all aspects of decision making about their care and treatment. People were encouraged to be as independent as possible.

Staff spoke positively about the management team and said both the registered manager and the deputy manager were supportive and approachable.

The premises were well maintained. Regular health and safety checks were conducted for equipment and the building. The home was clean and tidy throughout, with infection control procedures followed as required.

The provider ensured systems were in place to protect people from abuse. The service conducted a robust recruitment process. Staff had completed training to ensure they were able to recognise the types of abuse and take appropriate action. Safeguarding concerns and accidents and incidents were investigated and analysed to identify any trends.

People were encouraged to take part in a range of activities and had opportunities to access the wider community.

Following the inspection the provider took immediate action to address the concerns identified. However additional concerns were raised about the safety and welfare of people. We carried out an additional day of inspection to look at these concerns. A meeting was held with the provider to gain assurances that people were safe and the issues would be addressed. The provider gave assurances and produced action plans outlined it's intended actions.

The overall rating for this service is 'Requires Improvement'.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always administrated safely.

People did not always receive safety checks and clinical observations when they needed them.

Some risks to individuals had not been assessed to ensure they remained safe.

People and relatives gave mixed comments regarding staffing levels.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not act in accordance with the Mental Capacity Act 2005.

Training was up to date.

People were supported to maintain a balanced diet and access healthcare services when needed.

Is the service caring?

Good

The service was caring.

We observed caring interactions between staff and people living at the home.

People were treated with dignity and respect.

Staff supported people to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans contained contradictory information.

Activities were available to people to participate in if they wished to.

People and relatives knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

Significant risks to people that we identified during our inspection, such as; the failure to ensure that people were repositioned and have regular safety checks and observations, poor fluid intake, unsafe administration of medicines, incorrect PEEPs and contradictory information within care records had not been identified during audits. Failure to identify these risks placed people at risk of harm.

There were opportunities for people, relatives and staff to provide feedback about the home.

Staff told us they enjoyed working at the service and were supported by the management team.

Tennyson Wharf

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 23 January 2019 and was unannounced. This meant the provider did not know we would be visiting. Two further days of inspection took place on 24 January 2019 which was announced and 11 February 2019 which was unannounced.

The inspection team was made up of 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.

We reviewed other information we held about the service, including any statutory notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service and the local authority safeguarding team, the local Healthwatch and the clinical commissioning group (CCG). 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 11 people living at the service and six relatives. We also spoke with the registered manager, deputy manager, two nurses, one senior, three care staff, chef, maintenance staff member, an activities coordinator, an administrator and two support staff.

Following the inspection we spoke with the regional manager.

We reviewed seven people's care records and four 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.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Tennyson Wharf. One person said, "Yes, safe here. I'm comfortable here." Another person said, "I know if I need help there is someone there."

We found medicines were not always administered safely. The service failed to follow NICE guidelines and the provider's own medicines policy. This meant people were placed at the risk of harm.

One person received their medicines covertly (medicines that are administered in a disguised format without the person's knowledge.) The record of decision to administer medicines covertly dated 14 November 2018 did not show any involvement of a pharmacist and clearly gave guidance to obtain such advice. The registered manager stated that the service had consulted the local pharmacy for guidance regarding safe administration but they were unable to provide a record of the conversation or the guidance given. They said, "We didn't get a response from the pharmacy re covert meds." We spoke to one nurse who told us that the person's medicines were crushed and placed in either food or a drink. On our request they consulted with a pharmacist. It identified that three of the medicines should not be crushed, one should not be crushed as it could cause an upset stomach. Another nurse we spoke with told us they did not crush the medicines but placed the tablets whole or emptied a caplet in to yoghurt, this method had not been confirmed as appropriate by a pharmacist.

Another person's medicines were administrated by a percutaneous endoscopic gastrostomy (PEG). This is where a tube is placed into the stomach to enable people to eat and drink when they are unable to naturally. A document which described the requirement of obtaining advice from a pharmacist was unsigned. The service requested a pharmacist to review the risk assessment in June 2018 and did not follow up the issue until after our inspection when we highlighted the matter. In that period of time the service administered the medicines without confirmation it was safe to do so. We noted this failure had not been identified in the medicines audit dated 20 September 2018 as it was stated in the audit record that the issue of administering medicines had been discussed with a pharmacist.

The service did not always follow NICE guidance in relation to hand written medication administration records (MAR). We found a number of MARs had only been completed by one staff member and had not been checked for accuracy and signed by a second trained and skilled member of staff before its first use.

Medicines were stored securely in a lockable cabinet in people's rooms. Controlled drugs and medicines that required refrigeration were stored in a treatment room on each unit. We noted one fridge had a recorded temperature above the safe range since December 2018. Whilst staff had been resetting the temperature daily the matter had not been referred to the registered manager or maintenance team. This meant that the quality of medicines may have been compromised, as they had not been stored under required conditions. We alerted the nurse to our findings and asked them to address the matter.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were in place in relation to medicines, and specific plans in relation to the administration of pain relief prior to mobilising was detailed for one person who was recovering from a fracture. A staff member said, "PRN [as required medicines] protocols are now in place." The registered manager said they were aware 'as required' medicine protocols needed more personalised information.

We observed medicines being administered to people in their rooms. Nursing staff knocked on people's doors, explained why they were there and entered people's rooms closing the doors behind them. Once people had taken their medicines staff exited the rooms asking people if they would like their doors open or closed.

Risks to people had not always been identified and mitigated. For example, a moving and handling risk assessment stated a person had epilepsy however there was no specific care plan or risk assessment in relation to epilepsy. Another person had an episode of aspiration pneumonia whilst in hospital this fact had not been highlighted and taken into account within their choking risk assessment.

Some people were identified as being at very high risk in relation to skin integrity. We identified three people who required support to prevent skin deterioration. Their care plans stated staff were to complete a repositioning chart at intervals of between two and four hours. Records showed that people were not always repositioned to alleviate pressure. We noted 13 separate occasions where people were not repositioned according to their care plans and on some occasions people were left for up to eight hours without being repositioned. The lack of repositioning placed people at risk of harm.

People were at risk of dehydration, care records showed that one person was not receiving sufficient fluids to aid their recovery from skin breakdown. We noted that on four separate days the person received less than 800mls of fluid and on one day their fluid intake was recorded as 450 mls. We found no written evidence of why the person had so little to drink and no action plan or further risk management to address this. Another person was not having their fluid intake monitored. Their care plan stipulated that fluid intake should be recorded due to a high risk of pressure ulcers developing. The lack of recording, planning and risk management placed people at risk of harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Reviews of risk assessments were completed monthly, however they only contained a date and signature. There was no information in relation to the content of the review or affirmation that the assessment remained appropriate to minimise risks to people.

During our inspection we observed people were left unattended for periods of time whilst staff supported other people. 14 people lived on one unit with four people needing two to one support. One senior and carer were allocated to support on the unit which meant when staff supported people no other staff were left on the unit. A staff member told us, "We have to call staff from another unit but sometimes we can't always get someone [staff member]."

Relatives, people and staff had mixed opinions about staffing levels. One person said, "Definitely, there's always someone about, there seems to be a lot (of staff) but they always seem to be swept off their feet. I don't bother them a lot." Another person told us, "No, they're short staffed. At night-time it might take a long time for someone to come." A relative said, "The staff are amazing but there's too many people to support. People have a range of needs and the carers do their best but with two it's not enough. The basic problem is staffing."

A staff member said, "There aren't enough staff on Keats unit, everyone has a dementia so there's not enough, I think we provide the right care but sometimes three just isn't enough. We would benefit from extra staff when people are getting up." Another relative said, "There is some sickness so we notice a staffing issue but there seems to be more productivity." A nurse said, "There's enough staff, some regular sickness which is frustrating."

The registered manager told us the provider used a dependency tool to determine the appropriate staffing levels and the service was staffed above the required number calculated. We suggested that the service reviewed its dependency tool and reflect on the deployment of staff. When we visited the service on 11 February we reviewed staff allocation information and rosters. We found some inconsistencies which identified several occasions when staffing levels were lower than the level indicated by the dependency tool.

Since our inspection further concerns have been raised with the registered provider regarding safe staffing levels. We have been provided with assurances that safe staffing levels will be maintained and the registered provider will undertake a comprehensive review of people's needs on an ongoing basis to ensure that people receive the support they require.

People did not always receive safety checks and observations when they needed them. We looked at the care records of four people relating to this. Care plans stated that they required periodical safety observations at two hourly intervals. We noted over 40 separate occasions where people's safety was not checked and on some occasions people were not checked for up to 10 hours. The lack of safety checks and observations placed people at risk of harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal emergency evacuation plans (PEEPs) did not accurately reflect people's staffing support needs during an evacuation. For example, people who mobilised with the use of a wheelchair required two staff members for a safe transfer however, it reported one staff member was needed. The regional manager assured us that the PEEPs would be reviewed and five staff members at night was enough to support people for a safe evacuation.

Safeguarding concerns were logged and investigated. The local authority safeguarding team received a copy of the provider's safeguarding concerns log on a regular basis and confirmed via email that appropriate and proportionate action had been taken.

Accident and incident report forms were completed following any accidents and included details of the investigation which included actions required to prevent a reoccurrence. This included information such as referral to the falls team, and requests for GP visits. The registered manager described how incidents were analysed to identified trends or patterns. They said, "There's analysis completed for each individual and for the community. That way we can identify if any specific referrals need to be made for the person or if there are issues on each community such as staffing."

Safe recruitment practices were followed which included an application form, interview and the receipt of two satisfactory references and a Disclosure and Barring Service check before commencing in employment. Nurse's Nursing and Midwifery Council (NMC) registrations were valid and monitored. All nurses must be registered with the NMC. The NMC is the regulator for all nurses and midwives in the UK.

The maintenance person had effective systems in place to ensure all premises and equipment checks were

completed in a timely manner. Any reactive repairs or maintenance issues were addressed. Fire drills and simulated evacuations were completed with staff who worked day shift and night shift. A sprinkler system was in place and the fire alarm was fully addressable. The maintenance person said, "I love what I do, I'm passionate about it, I'm excited to come to work and I'm happy, my job is great."

All the communal bathrooms were being used for the storage of wheelchairs and hoists when we arrived. We asked the staff member to address the matter and the items were removed. The maintenance person said they had previously raised this as a concern. The laundry area was well organised with separate soiled and clean areas to minimise the risk of cross infection. Staff had access to personal protective equipment (PPE).

Requires Improvement

Is the service effective?

Our findings

During the last inspection in January 2017 it had been identified that the provider was not always acting in accordance with the MCA Mental Capacity Act (2005). At this inspection we found continued concerns in relation to this.

The mental capacity assessments and best interest decisions viewed were signed by no one but the staff member completing them. One person had a best interest decision in place related to the use of bed rails, however when we spoke with the registered manager they said the person had been re-assessed and it had been decided that the use of bed rails was no longer in the person's best interest as the bed was beside the wall and a sensor mat was in place. There was no evidence that this had been documented or updated in the care file.

It had been documented that one person had not been included in a mental capacity assessment and best interest decision making because the staff member felt it was, "not fair to wake them up." A staff member said, "We are getting there with MCA, there's a big improvement. They are done for advanced care planning and end of life care, DoLs, DNACPR. We liaise with the family and get them to sign them."

A relative said, "I have lasting power of attorney of health and wellbeing and property and finances and I'm involved in best interest decisions. I've gone through the care plan with [staff member] and I'm happy that interventions are in her best interest." Some best interest decisions were documented however they were not signed by all the people who had been involved in the decision making and there was no evidence of what alternative measures had been considered to support the person.

During December 2018 supervisions had been held with nursing staff where mental capacity assessment and best interest decisions were discussed. Staff were to start to ensure care plans included mental capacity assessments and best interest decisions for people who lacked capacity. The homes action plan identified that mental capacity assessment were not in place for each specific decision to be made. The action was to ensure assessments and best interest decisions were in place in respect of each specific decision to be made for people where there was a reason to doubt capacity. This action was scheduled to be completed by 7 December 2018.

The registered manager agreed that best interest decisions were not always decision specific. They said, "We are glad you've picked it up now so we can do something about it."

We discussed best interest decisions with the deputy manager and they understood the process however they had followed instruction of the clinical development nurse.

The regional manager advised that a clinical development nurse had directed the management team incorrectly in regard to the implemented of MCA. They assured us that the matter will be addressed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People's needs were assessed before they were admitted to Tennyson Wharf. There was some specific information in relation to people's needs however the assessment included limited information in relation to equality, diversity and human rights, for example protected characteristics. This meant the service did not capture all the protected characteristics to ensure people were protected from discrimination.

A 'new person checklist' was used to ensure documents were completed in a timely manner after people moved in, for example risk assessments had to be completed within 24 hours and care plans with seven days.

Staff we spoke with told us they felt supported and had taken part in supervisions and appraisals. A staff member said, "The staff are happier and supported, there's supervision if there are any issues around care input. They probably happen about five or six times a year. The deputy does appraisals and performance development reviews."

People told us they thought staff received enough training to support their needs. Mandatory training the provider deemed necessary was monitored and up to date. Training included areas such as safeguarding, moving and handling, infection control and fire safety. A nurse said, "We are supported, lots of clinical training and clinical supervision. No improvement needed I'm happy with everything."

A varied diet was provided and people were supported with mealtimes, some people had family members who visited them daily to provide one to one support with meals. Written menus were on display however the day was incorrect which could have caused confusion for some people. We did not observe any pictorial information or showing of plated meals to support people with decision making.

People told us they enjoyed the meals available. One person said, "No complaints. I tend to eat in my room, I prefer to." Another person told us, "They should be coming round with a drinks trolley. There's a menu, I prefer small portions." A relative said, "The food is fine." Another relative told us, "It's a nice menu, but people have their midday meal and are then asked about their tea time meal. They don't want to think about food when they've just eaten."

Each unit had its own kitchen area where people and visitors could make their own drinks and have a snack. The communities for people living with a dementia had key activated hot water systems to minimise the risk of scalds. Tables in the dining room were laid for lunch with table cloths, fresh flowers, clean cutlery and glasses. Staff were knowledgeable about people's dietary needs and supported people in line with guidance within care plans.

There was evidence to show that referrals had been made to the falls team, speech and language therapy and that guidance had been sought from GPs and pharmacy services, however these were not always followed up on so the provider could not clearly demonstrate that external professionals were involved when required. People told us when requested the service supported them to attend appointments with healthcare professionals.

The premises had wide corridors and open areas to support people with wheelchairs. Each bedroom had an en-suite shower and toilet for people's personal use, in addition to the adapted bathrooms.

Good

Is the service caring?

Our findings

People and relatives told us they were happy with the care and support they received. One person told us, "They look after me well." A relative said, "My [family member] is happier here than at home." They added, "It's very good, [family member] is more than happy, they have company, they are hoisted, have personal care and are looked after." We were also told, "There are some lovely staff who care about what they do and are very helpful. I commend them for the care, it's admirable. Staff are dedicated to what they do." Another relative told us, "Yes, I can't speak highly enough of them."

We observed warm and caring engagement with people from the assistant administrator who offered reassurance to a person living with dementia who was distressed about where their relative was. They were not challenged about this and were spoken to a calm and reassuring manner.

Compliments had been received in relation to the care provided by staff, for example, "We are thankful that [family member] is being truly cared for, you are totally in tune with her and her health needs."

People and relatives told us they were involved in decision making and planning of care. One person told us, "Yes, they do involve us."

People were supported to have contact with their families and maintain relationships. Relatives told us they were made welcome at the service. One relative said, "I am made very welcome." Another relative told us, "They always take time to say hello and update me." Another relative said, 'Yes, they will speak to me or if mum is having any problems, they'll let me know.'

People were treated with dignity and respect. We observed staff were polite and friendly when supporting people. The service had a privacy door marker system, 'Personal care being delivered.' signs were displayed when people were being supported in their rooms. People told us staff knocked on doors and sought permission before entering.

People we spoke with were supported to be as independent as possible. Staff were knowledgeable about the level of support people needed at meal times, during personal care and mobility. We observed staff offering encouragement and verbal support. They promoted people's independence and only intervened on the request of the person.

People's confidential information was stored securely and only accessible by staff who needed the information to support them in their role. Staff were sensitive when discussing people's care and ensured this happened privately.

People received a service user's guide which outlined the service and contained useful information regarding support and advocacy services. The provider had a policy for promoting equality and diversity within the service, supporting both staff and people using the service. Equality and diversity also formed part of the provider's 'Service users' rights.'

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always contain enough information to ensure people were supported safely and in line with their preferences. Documents including pre-assessments and risk assessments were not always completed fully.

Within one person's pre-assessment it mentioned the person was diabetic and had angina. No care plans or risk assessments were in place to support staff to ensure the person's needs were met. The service had recognised that due to clinical needs some people required their fluids monitored. We found fluid charts were in place however these were not always completed and calculated at the end of the day.

One visitor spoke with us at length about their family member's needs. We found some of this information was not included within the person's care records. For example, instances when hoists or stand aid hoists should be used and that the person could be anxious and resistive to personal care. A staff member confirmed with us that a stand aid hoist was used if required and this was assessed at the point of each transfer dependant on the person's mobility. They also described how the person may physically push staff away during personal care. This information was not included in the person's plan of care. Their risk assessment for moving and handling stated, 'needs full support and guidance from all staff for all requirements of moving and handling.'

Other care records contained contradictory information which may compromise the receipt of safe care and support. Examples of this included contradictions in relation to whether specific pieces of specialised equipment should or shouldn't be used by care staff. Staff explained that the equipment was not to be used, however the plan of care in relation to the person stated the equipment should be used. In addition, the care plan stated the person had a shower every other day unless their condition was such that this was not suitable. A risk assessment was in place that stated the person was to have bed baths due to the risks associated with showering being too great.

Care plans were in place in relation to specific clinical support, for example, oxygen use and the use of a PEG.
Care records included people's personal life history which included some background to their family and friends, work history, key memories and bad memories which may cause distress.

Daily activities were displayed in the reception area. A gentleman's club was held every Wednesday and men from the local community were invited to attend. One of the activities was watching races and placing 'bets' with the activity coordinator.

Two activity coordinators were employed to cover seven days a week. During our inspection we observed people from all units were encouraged to take part in activities in the café area including dominoes and singing bingo. Some people took part in a walk around the marina. The chef told us they had recently organised a curry tasting afternoon which had been a success. People had access to WiFi and SKY television in their rooms and many people chose to stay in their rooms.

The service supported people with their religious needs and a church service was held monthly.

An activity meeting in December 2018 had raised the purchasing of sensory equipment for the dementia community as it had been recognised that people were not joining in with many, if any, of the activities.

People and relatives were aware of the complaints procedure. One person told us, "I don't know, I just have a word with someone, I've never had reason to complain.' A relative told us, "I would have a word with the manager."

One visitor said they had raised concerns about care and were happy with how this had been dealt with and addressed. Another visitor said, "Communication is very good. You can go straight to [registered manager] and things are followed through."

A range of complaints had been received in relation to care and staff. They had been investigated and outcomes shared with the complainants. Action had been taken to address the concerns which included explanations to the complainant, the introduction of new systems to ensure newly prescribed medicines were received and commenced in a timely manner and, in some cases, disciplinary action in line with HR procedures.

'Resident, families and friends' meetings were held monthly. People and relatives were encouraged to regularly offer feedback. The service offered a 'resident ambassador' they promoted the service showing people around the facilities, and were a voice for people living at the service.

Nobody was receiving end of life care at the time of our inspection, but policies and procedures were in place to provide support when needed. A relative said, "We were involved in [family members] care plans, an advanced decision has been made to stay at Tennyson Wharf rather than go into hospital." People's care records included advanced care plans which detailed where people should be treated and when they wanted to receive hospital treatment, for example, infections to be treated at home and broken bones to be treated at hospital.

Inadequate

Is the service well-led?

Our findings

The service had a range of governance tools to monitor and assess the quality and safety of the service. We found these were not always effective. Significant risks to people that we identified during our inspection, such as; the failure to ensure that people were repositioned and have regular safety checks and observations, poor fluid intake, unsafe administration of medicines, incorrect PEEPs and contradictory information within care records had not been identified during audits. Failure to identify these risks placed people at risk of harm. Following the inspection the provider told us that the way some of the audits were conducted by the management team were not in line with company expectations.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider took immediate action to address the concerns identified. However additional concerns were raised about the safety and welfare of people. We carried out an additional day of inspection to look at these concerns. A meeting was held with the provider to gain assurances that people were safe and the issues would be addressed. The provider gave assurances and produced action plans outlined it's intended actions.

A documentation audit was completed on a rotation of 10% of care records within each community. The registered manager told us, "It's a tick list really of what's in place and what isn't." There was no detail recorded as to the quality or accuracy of the records being audited.

The registered manager explained that they were aware that the audit document did not assess the quality or accuracy of the records so 'resident of the day' checklists were being used to assess quality.

Resident of the day checklists included the review and update of care documentation. One person's checklist had been completed a week prior to the inspection and had not identified any concerns in relation to care documentation. It stated that documents had been rewritten but there was no assessment of the quality or appropriateness of information. Monthly care profile reviews were also completed, these detailed whether care documents were in place and whether they had been changed but there was no detail in relation to what the change was or the appropriateness of information recorded.

Nutrition care and dining audits were completed monthly and assessed the dining experience, as well as people's nutrition and hydration. These had not identified any areas as needing improvement. Daily walkarounds were completed two or three times a day, however only one document was completed and the times were handwritten at the top of the walkaround check. It was not evident which, if anything, had changed on the different walkarounds. There was no specific information in relation to the communal bathrooms and whether they were routinely used to store wheelchairs and hoists. Following the inspection and receiving feedback from the inspectors about the concerns identified, the provider made improvements to this process.'

Unannounced out of hours spot checks were also completed. They had raised that staff needed to complete fluid charts in real time, and bed rails and repositioning charts were completed and up to date.

Quality improvement reviews were completed every four months and any identified actions were transferred to an action plan. The latest quality improvement review completed in October 2018 showed that there were 26 issues identified within the review that had been raised in previous reviews. It was also noted that discussions had been held in relation to capacity assessments and best interest decisions and these should be decision and time specific. Other concerns highlighted related to medicine management and care planning, risk assessing and documentation.

The action plan management tool documented areas which required improvement and what the required action was, there was an agreed date documented, however the agreed dates for all 19 actions identified had passed and there was no record that improvements had been made or action taken. We were told that once the required improvements had been made the issues were removed from the action plan.

People and relatives told us they felt Tennyson Wharf was well-led. A relative said, "Since [registered manager] has been here there's more team work, the housekeeper, kitchen and care staff all work together." They added, "Very good manager, very capable and we are very impressed, there's a good team." Another relative told us, "They do a great job."

Staff were also complimentary of the registered manager. One staff member said, "They are inspirational, you can go to them for anything." Another staff member told us, "They are approachable as is [deputy manager]." A staff member said, "Manager and deputy are amazing support, they want to do the right thing by the staff and residents, person centred care is paramount. They want to lead a good team."

Staff told us they enjoyed working at Tennyson Wharf. One staff member told us, "It's the best care home I've worked in." Staff we spoke with told us they were regularly consulted about the running of the home. The provider had a scheme for recognition for 'amazing care and hard work.' Employee of the month was displayed in the main entrance.

General manager bulletins were received which provided updates for the registered managers. Some information was described as essential, some for taking note/action and some for information only. Information being shared included that three yearly DBS checks were to cease with immediate effect unless there was a contractual agreement to complete them. Other information included the completion of feedback surveys and details for open days.

A range of meetings were held which included open discussions around any concerns or areas for improvement, including communication and team work.

A staff member said, "Since the last inspection we have worked really hard, it was difficult to pick it up and it has been trying at times but its brilliant to see the improvement." They added, "I am proud of my job, people are well looked after, clean and cared for."

The service supported people to remain part of the local community and was proactive in promoting the service to other people in the wider community. The registered manager regularly attending local provider networking groups. Records showed the service worked in partnership with people's local authorities, multidisciplinary teams and safeguarding teams ensuring people received joined-up care.

The registered manager had notified the CQC of all significant events which have occurred in line with their

legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in accordance with the Mental Capacity Act 2005 (MCA). Regulation 11(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to ensure that people's assessed needs were met. Regulation 12(1). The service did not ensure medicines were administrated in a safe way. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17(2)(a).