Indigo Care Services Limited

Sister Dora Nursing Home

Inspection report

Brocton Road
Milford
Stafford
Staffordshire
ST17 0UH

Tel: 01785661024

Date of inspection visit:
23 November 2016

Date of publication:
14 February 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 November 2016 and was unannounced. We found that people were not provided with safe care and treatment they were not supported to consent to their care, treatment and support, there were insufficient staff to keep people safe and the service was not well led. We identified numerous Regulatory breaches.

The overall rating for this service is Inadequate and we are now considering the appropriate regulatory response to the problems we found. 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.

Sister Dora Nursing Home provides support and care for up to 47 people, some of whom may be living with dementia. At the time of this inspection 33 people used the service.

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.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not receive their planned care. Staff did not follow people's management plans or instructions from health care professionals to ensure people's risks were reduced. This had a major impact on people's well being and they were at high risk of receiving inappropriate care that did not meet their needs and reflect their preferences.

Medicines were not managed safely. People did not receive their medications as prescribed, at the time they were due or in a safe way. As a consequence people were at a high risk of receiving inappropriate care and treatment which would significantly reduce their quality of life.

People were not always protected from the risk of abuse. People sustained injuries, some unexplained and some caused by staff working practices, which had not been analysed effectively, which meant the risk of further incidents was not reduced. Incidents of suspected abuse were not reported or investigated. People were at high risk of harm because no action was taken to mitigate the identified risks.

There were not enough suitably skilled staff available to keep people safe and meet people's individual care needs. There was a lack of leadership, the nurses and senior staff were not in sufficient numbers to supervise, monitor and guide staff to ensure good care and support was provided. Staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe. As a consequence people were at a high risk of unsafe and inappropriate care because there were not sufficient suitable skilled and competent staff available. This had a major impact on ensuring people were safe and their health and well being was assured.

People's health and nutritional needs were not consistently monitored and managed effectively to promote their health, safety and wellbeing. People were at high risk of deteriorating ill health, malnutrition and dehydration because their care and support needs were not well managed or monitored.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure decisions were made in people's best interests when they were unable to do this for themselves. People were being unlawfully restrained and restricted, care and treatment was provided against their will. Staff did not always show they respected and understood people's rights to make choices about their care.

Complaints were not acted upon to reduce the risk of the complaint arising again. The provider did not have effective systems in place to assess, monitor and improve the quality of care. People who used the service were placed at extreme risk of harm and actual harm because the service was not safe, effective or responsive to their individual care and support needs and not well led.

We found numerous breaches of the Regulations of The Health and Social Care Act 2008 (Regulated Activities) 2014 and issued an urgent notice of decision to suspend all new admissions into the service until we had the assurance that people who used the service were safe and the risks to peoples' health and well being was reduced.

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 safeguarded from abuse as concerns were not raised with the local authority when people sustained unexplained injuries.
There were insufficient suitably trained staff to meet the needs of people in a safe and timely manner. Risks to people were not always minimised as staff did not always follow people's risk management plans. Medication was not managed or administered safely. People were at extreme levels of risk of harm and injury.

Is the service effective?

Inadequate

The service was not effective. People did not always consent to their care, treatment and support. People's individual nutritional needs were not met. People did not receive the healthcare support they needed. Staff felt supported and trained however this was not reflected in their care practices.

Is the service caring?

Inadequate

The service was not caring. Staff did not have time to spend quality time with people. Staff did not show they understood people's individual needs and behaviours that were linked to their specific requirements. People's privacy, dignity and self-esteem were not promoted or respected.

Is the service responsive?

Inadequate

The service was not consistently responsive. People did not receive care that reflected their needs and respected their preferences. Complaints were not always acted upon to reduce the risk of the complaint arising again.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. Effective systems were not in place to monitor safety incidents, so action was not taken to reduce the risk of further harm from occurring.

Sister Dora Nursing 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 25 November 2016 and was unannounced.

The inspection team consisted of two inspectors.

We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with eight people who used the service; they were able to tell us their experiences with the service. We spoke with all other people who used the service, however due to their communication needs they were unable to provide us with detailed information about their care. We observed people's care in the communal areas and visited people who were in their bedrooms at intervals during the day.

We spoke with four relatives of people who used the service to gain feedback about the quality of care. We spoke with the registered manager, the regional director, the nurse on duty, one senior care staff, four care staff, the activities coordinator and members of the ancillary team. We looked at eight people's care records, staff rosters, two staff recruitment files and the quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

After the inspection we shared safety concerns with the local authority because we had significant concerns about people's health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

Risks to people's health and wellbeing were identified and reviewed but not always managed in a safe way. We observed a person was asleep and unresponsive in bed with a plastic apron around their chest and neck. Plastic aprons were provided to people at meal times and used as a clothes and linen protector. We saw monitoring records which instructed staff to check the person's welfare at regular intervals. Staff were not in the vicinity to ensure the safety and comfort of the person and they were at risk of strangulation and choking. We alerted a member of care staff regarding the compromising situation; they removed the apron and said the person 'doesn't look well'. Staff including the trained nurse, who earlier in the morning had administered medication, had not noticed the person to be unwell and had not attended to the person's needs at the times she required support as detailed in the monitoring records. We spoke with the nurse and the registered manager regarding our observations and they agreed that a doctors visit was needed. This person was at risk of injury, harm and discomfort.

We saw another person had sustained two skin tears to their arms, which had been recorded as 'inflicted by staff during moving and handling'. Both injuries had been recorded as incident/accidents but no action had been taken to reduce the risk of further harm. We looked at the moving and handling care plan for this person it recorded: 'Skin is very frail and thin and at high risk of damage. Staff to be cautious during moving and handling'. We spoke with the registered manager regarding our observations, they informed us that a senior staff member had the responsibility for training care staff in moving and handling and that all staff had received this training. Staff did not follow instructions recorded in the risk assessments; action was not taken to mitigate the risks for this person. Consequently this person was at risk of further injury and harm and was not provided with safe care.

Some people had poor mobility and needed support with transferring to and from different areas of the service. Staff told us and we saw a person was unable to transfer independently and required two staff to support them. The person's needs had been assessed which identified the use of the mechanical hoist and a slide sheet for all transfers. We observed the person was slipping out of their chair and needed support to reposition. We directly observed two care staff drag lift and manually handle the person in the chair. A drag lift is where the carers place a hand or an arm under a person's axilla (armpit), to assist a person to change from one seated position to another. This is an unsafe and high risk practice which may cause injury to both the person and staff and is no longer considered to be good practice. The mechanical hoist and the slide sheet were not used as planned. We spoke with the registered manager regarding this practice, they were unaware that staff were utilising this unsafe technique, they spoke with the staff concerned and told us staff would receive further training in moving and handling. However, this person was not provided with safe care and was at extreme risk of injury, harm and discomfort.

Some people were at risk of developing sore skin and tissue breakdown because of illness or frailty. Assessments had been completed when the risk had been identified and plans were in place to manage these risks. However, we found people did not always receive their planned care to manage their risk of skin breakdown. For example, one person's care records stated they needed support to change their position every two hours. We observed another person was not provided with pressure relief for a period of five

hours. We saw their care needs had been assessed and support plan advised staff to support the person with repositioning every two hours. Staff were aware of this person's needs but told us they didn't always have sufficient time to support the person in line with the instructions. This person was at great risk of developing pressure ulcers and sore skin because the care and support plans were not followed. We spoke with the registered manager who was unaware of this, they instructed staff to support the person with pressure relief. This person was not provided with safe care and was at extreme risk of developing sore skin and discomfort.

Some people had been assessed as at risk of choking and needed their drinks thickened to a consistency where the risk was reduced but people were still able to have sufficient fluids. The thickening powder was evident in people's bedrooms, and a monitoring chart had been completed with the instructions of how much thickener to use for a specified amount of fluid. We saw a person had been assessed as being at high risk of choking and required thickened fluids. However we observed the person's drinks had not been thickened as required. A member of care staff told us the person should have thickened fluids because of the risk of choking but was unsure why this had not been provided. This meant the person was at great risk of choking and harm due to unsafe and unreliable care and support.

We noticed a person's mouth was full of white powder. Staff were not in the vicinity to ensure the person's safety and comfort. We asked the nurse on duty to check the person as we had concerns the person was at risk of choking; they told us the white powder was 'thickener'. This meant the person had received thickener which had been administered in an unsafe way; the thickener should be added to fluids and dissolved before swallowing. This person was at risk of harm and of choking.

We looked at the way the service managed medicines. We saw a person was prescribed a medicine that was to be added to food or with milk. There were clear instructions recorded on the medication administration record (MAR) that supported this. We saw the nurse did not adhere to these instructions but added some thick and easy powder to the medicine. We asked the nurse on duty why they did not follow the prescribing instruction they said "I didn't notice the instructions'. The instructions were not adhered to and so this person was at risk of aspiration, choking and receiving their medicine in an unsafe way.

We saw another person had been prescribed pain relief in the form of weekly analgesic patches. We looked at the MAR and saw it was clearly identified when the weekly medicine was due. The nurse on duty had administered medicine to this person earlier in the day but confirmed to us that they had not noticed this weekly analgesic patch had not been given on the due day and was outstanding. This meant this person did not receive the medicine when it was required and so was at risk of experiencing pain and discomfort.

Some people had been prescribed external creams and ointments to help manage their risk of skin damage. Some but not all of the topical medications administration records (TMAR) included the type of cream to be applied, to which part of the body and the frequency. There were many gaps on the TMAR chart so we could not determine if staff followed the administration instructions and people received their treatments as prescribed. We found external creams in people's rooms with no prescription labels on them, or did not relate to the person residing in the room and for whom they were being used.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew about the safeguarding and whistle blowing procedures and told us they would speak with senior staff or the registered manager if they had concerns regarding the safety of people. The registered manager told us they would refer any concerns in relation to the safety of people to the local authority, they had not

made any referrals recently. Our records showed no concerns had been raised with the safeguarding team during the last six months. However we saw that some people had sustained injuries and bruising to their arms. We saw two people had significant bruises to their arms and staff told us they were unsure of how these injuries had occurred. No record had been made of the injury and no investigation had been completed to find out the cause or what action could be taken to ensure the risk of further injury was reduced. Another person's care records showed they had sustained injuries to their arms from staff during care delivery. These incidents had not been discussed with or investigated by the local safeguarding team. Therefore people were not being protected from possible abuse as the safeguarding procedures were not being followed.

These issues were a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told that 32 people used the service of which 18 people had been assessed as requiring nursing care. Care staff told us 23 people were highly dependent and vulnerable in terms of their need for care and attention as they needed support from two care staff at all times. The registered manager told us staffing levels were at a constant minimum level and decreased during the course of the day and were significantly lower at night. The registered manager told us that the dependency needs of people were not an indicator or determinant for the staffing levels but stated the staffing would remain the same even when the service was at full capacity. One person told us, "I don't like to bother the staff as they are so very busy". Staff told us they were always very busy and rushed. A member of staff told us they didn't have time to reposition people when they should. We saw that people experienced delays when care and support was required. For example people did not receive support with pressure area or continence care, and people experienced delays in receiving their medication. There were insufficient staff to meet people's needs.

Some people required help and support with their continence needs. Staff told us that most people used continence aids but were still asked if they wished to use the toilet. We observed one person requested assistance to use the toilet. We saw staff assisted them to access the toilet but then the person had to wait 45 minutes until staff were available to support them with their personal care needs. During this time the person became very distressed and was crying. Another person wore an incontinence aid which was not checked or changed for a period of at least eight hours. Staff did not offer any help or support. The person was at risk of developing sore skin and moisture lesions due to the lack of attention and support to their continence needs. People were not provided with safe care and support because sufficient staff were unavailable and people were at risk of unease and discomfort.

This constitutes a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities).

The registered manager told us they were recruiting new staff and had recently recruited registered nurses and care staff. We looked at the way staff were being recruited and saw that pre-employment checks were carried out including a disclosure and barring service check (DBS) to ensure they were fit to work with people.

Inadequate

Is the service effective?

Our findings

Staff told us they felt supported by the registered manager and senior staff and had the opportunity to discuss any training or work related issues. One staff member told us their training requirements, including moving and handling and pressure area care, were all up to date. They confirmed they had on-going updates and refresher training. Staff told us the training provided was mainly online training with some practical sessions completed with senior staff. We saw records and training certificates in the personnel staff files we looked at. However during this inspection we saw inappropriate and unsafe moving and handling techniques, medicines management was unsafe, continence and nutritional support was poor, and people were provided with ineffective skin and pressure area care. Staff did not have the knowledge and skills needed to follow the Mental Capacity Act, we saw people did not consent to their care and treatment and some people were being illegally restrained. This meant that staff did not put the theoretical training into practice and people were placed at risk of harm, injury and discomfort.

This constitutes a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities).

The provider was not following the guidance of the Mental Capacity Act 2005 (MCA). The 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's capacity to consent had not been assessed making it difficult to ascertain the level of decision making abilities for each person.

Staff told us and we saw many people were cared for in bed and did not, or were unable to, get out of bed. Many people who were cared for in in bed could not express their wishes and were reliant on staff for support. Mental capacity assessments had not been completed to identify if these people could consent to their care and support. There were no records to show that people, who were being restricted to spend long periods of time in their beds, had consented to this or this was in the best interests of the person. The guidance of the MCA had not been followed and we had concerns that this practice may have developed to assist staffing capacity and demands rather than meeting the needs of the people in question. This meant the service did not regularly assess and monitor people's individual needs to make sure the service was flexible and sufficient to meet people's individual needs and to keep them safe.

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 procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found that staff did not always follow the requirements of the DoLS. For example, we saw a person was very distressed as they were in bed and shouting out for help. This person was receiving foot care against their will. We observed a member of staff holding this person's hands restraining them so that the foot care could continue. We intervened and stopped the intervention. This person's care plan showed that they could become resistant with their care at times. The care plan stated 'can become aggressive if this happens, staff to leave them safely to calm down'. We saw this person was physically restrained against their will, and staff did not adhere to the plan of action or respect the person's

right to refuse their care. Staff did not appear to understand that this practice amounted to restraint and could be unlawful.

We saw another person sat in a chair that restricted their movement; this had not been agreed through the MCA process. No records had been made or were seen of the least restrictive options or full and proper consideration given to the health and safety risks by the use of these and other practices

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a person had been assessed as being at risk of choking and was unable to receive nourishment orally. Staff told us and we saw they had their daily nutritional needs provided by way of a PEG. Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube is passed into the stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate (for example, because of swallowing problems or sedation). Details of the feeding regime, devised by a dietician, were recorded in a care plan and on a document at the person's bedside. The feed was to be given at set times during the day. The person was due to be supported with nourishment at 1pm; we saw the person received this at 2.50pm, one hour and fifty minutes late. The nurse was unable to offer a reasonable explanation for the delay in providing the necessary support to this person. We saw the weight monitoring record for this person which recorded a weight loss of 7kg over a period of one month. An additional comment was included of 'error to reweigh'; there was no further record of any action taken to weigh the person again. This meant the staff were not effectively monitoring this person's weight and the person lacked the support they required for their nutritional needs and was at risk of malnutrition.

Staff told us and we saw some people needed support and encouragement with their nutritional needs. We saw one person had been losing weight; a plan had been put in place to reduce the risk of further weight loss. Their nutritional care plan stated they needed encouragement to eat and drink due to weight loss. At lunch time we saw they did not get any encouragement or support from staff and didn't finish any of the meals they were offered. Monitoring records were completed but were not in sufficient detail to ensure the person had sufficient to eat and drink each day.

Some people were prescribed food supplements to support them with their nutritional requirements. The food supplements were provided to people during the regular medication rounds. We saw one person was given a food supplement during the morning medicine round, it remained on a table in front of the person for the duration of the day, no encouragement or support was offered to the person and no reminder that they should drink it. This person's nutritional needs were not met.

These issues constitute a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs were not always met. People sometimes received support from other healthcare agencies when they required it, such as their GP, community psychiatric services and speech and language therapist. However we saw that the advice given was not always followed. For example people's prescriptions for thickened fluids were not being consistently followed. Guidance for supporting people with their nutritional, continence, pressure area care and medical needs were not always followed and people were at risk of harm and discomfort.

We saw and staff told us that one person frequently refused to accept their prescribed medication. The person's doctor had been contacted who instructed that if the person refused medication three times in one

day then the doctor should be notified. Staff told us this was an almost daily occurrence but we saw the doctor had not been notified since 14 October 2016. Staff were unable to identify and take the necessary action when people's health care needs had changed or when there was deterioration in health and wellbeing. This meant people were at risk of not having their healthcare needs effectively met.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service caring?

Our findings

People who used the service and their relatives had mixed views on how they felt they were cared for. One person told us: "I like it here, there is plenty of light". Another person said the staff were always too busy so they had to wait for help and support.

We saw some positive caring interactions but many negative ones. Staff we spoke with told us that they did not have enough time to spend quality time with people. We saw a person was visibly uncomfortable; this was recognised by a member of care staff who supported the person to a bathroom to attend to their comfort. However we saw another person in a bathroom, who was crying. A new member of staff (the first day at the service) was with them but was unable to support the person as they were unaware of the person's care needs. Both the person and the new staff member waited for 45 minutes before a more senior member of care staff arrived. We were told the senior care staff was delayed because it was their birthday and was being visited by their relative. This meant the staff member had neglected this person's personal care needs, leaving the person uncomfortable and distressed.

We saw people were not consulted when the music in the communal area was turned up, we heard a person complain to a member of staff. The music was turned down but no apology or further comment was made to the person by the staff member.

We saw one person shouting for help when they were being supported by staff. Staff ignored the pleas of the person and carried on with the intervention which was obviously causing the person great distress and anguish. The staff member did not show any comprehension or compassion to the person's situation, so we told the care staff to discontinue the intervention to ensure the person's anxiety lessened. This person was cared for in bed, unable to attend to their own needs independently and relied totally on staff support. Staff did not exhibit a caring compassionate approach with this person. We later saw this person alone in their bedroom, their anxiety had lessened.

We saw some instances where people's dignity was compromised. Some people needed support with continence care and were fitted with catheters to help them with urinary incontinence. We saw the equipment including a full bag of urine was clearly on show, the registered manager, the nurse on duty nor the senior care staff did not see this as a privacy issue. There was no consideration, or attempt made, to uphold and preserve this person's self-esteem and dignity with this very private care need.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We saw people experienced delays in receiving care and support from staff in a timely way. All people who used the service had an individual plan of care based on an assessment of their needs. There was no evidence to suggest people were involved with the care planning and review process. One person who used the service was not aware they had a plan of care and three relatives we spoke with told us they had not been involved in reviewing the care of their loved one. The plans gave an overview of people's care and support needs; however some staff did not know or were unaware of people's individual needs. For example we saw people were delayed in receiving support with their personal care needs because staff were unaware of their support needs. Staff were unavailable to provide support in a timely way and people did not get the care they required when they required support.

We saw one person was in bed, late morning, and was calling out for staff support as they wanted support to get out of bed. They were expecting visitors and wanted to be up and ready for their arrival. This person told us, "They [care staff] are never here when you want them." We spoke with the nurse who was unaware of this person's personal circumstances and reason why this person was anxious when they were delayed. The call bell to alert staff was out of the person's reach but was not working when we tried to obtain support. We spoke with the registered manager and informed them the call bell was not working, they were unaware as they had not been informed, however they immediately arranged for the call bell to be replaced. This meant staff were not responsive to this person's preferences which caused the person to become anxious and distressed.

We saw a person was totally reliant on staff to help and support them with their daily living activities. The person did not have any verbal communication and was sight and hearing impaired. The person's personal hygiene plan instructed staff to support with a daily shave. We saw the person with long whiskers and unshaven. The care plan for oral care detailed 'own teeth, brush with toothpaste at least twice a day. Person is nil by mouth, and lips and mouth become dry, cracked and sore'. The record for daily care interventions had not been completed for the whole of November 2016 to indicate any oral care had been provided and we saw the person's mouth and teeth were dirty. This meant staff were not responsive to this person's personal care needs; their preferences and needs were not met.

A person who used the communal areas told us they were 'short of breath'. We saw they had an inhaler which they used independently to help with their breathlessness. We asked if they had spoken with the nurse and they replied, "I have spoken with them but don't want to bother staff as they are too busy and have no time". We did not see that any action had been taken to contact the doctor for a medicine review to help this person with their health condition. Staff were not responsive to this person's physical healthcare needs so they were at risk of further ill-health and discomfort.

Staff told us that a person was at times resistive when they required help with their personal hygiene. We saw this person throughout the day had continued to refuse support; they were in a dishevelled and unhygienic state. Care staff told us they kept revisiting the person and offered help but they continued to refuse. We saw action had been taken to obtain the support from other agencies and advice and guidance

had been provided. However we saw the management plan was not being consistently followed. For example health services and the doctor had not been contacted when the person continued to refuse care and treatment three times in succession. The equipment that had been provided to support the person with their personal safety was not being used correctly. The sensor mat used to alert staff when the person was moving around was not in the correct position on the floor to be effective. The low rise bed had not positioned to a height that would reduce the person from falling out of bed. The lack of care and attention to detail placed this person at harm, discomfort and ill being.

Activities within the service were arranged each day. One person was preparing the bird feeders which were placed each day in the garden they told us there were many species of birds and they liked to watch them. One person said they were unable to see the birds and wildlife as they were sat with their back to the window. They had not been offered alternative seating. Many people stayed in their bedrooms for the majority of the time, it was the personal preference of some people but other people remained in bed because they were frail and poorly. The activity coordinator told us and we saw that they visited people each day in their bedrooms. Contact though from the care staff was limited to care interventions and so people were at risk of social isolation. We visited four people, who were in bed, throughout the morning and saw no stimulation had been provided. The people we saw were listless and lethargic.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they would speak with the registered manager or senior staff if they had any concerns or worries. Relatives we spoke with told us they had complained recently about the care their relative received. This was in relation to pressure area care and thickened fluids that were not provided. They told us they had not received any further communication or response from the registered manager since they had spoken with them about their concerns. The registered manager told us about the conversations they had with the relatives but confirmed this had not been recorded as an official complaint. Therefore we were unable to see the action the registered manager had taken to reduce the risk of the incidents occurring again. We looked at the person's care records and saw that since the complaint was made the person had sustained further skin damage. Records also showed that the person experienced delays with receiving effective pressure care. Complaints were not always addressed and action was not taken to improve people's experiences.

These issues constitute a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

There were systems in place to assess and monitor the quality of care provided but they were not as effective as they should be. Quality assurance checks, monitoring records and audits were completed, but were not effective to ensure people's health, welfare and safety were upheld. There was a failure to effectively assess, monitor and mitigate risks in terms of people's safety, health and welfare. This exposed people who used the service to an extreme risk of harm and actual harm.

People did not receive the care and support they had been assessed as needing at the time it was planned for. Pressure area care and repositioning for people as directed in individual care plans was not being carried out. We saw people experienced delays in their repositioning requirements and as such this resulted in some people developing pressure ulcers and sore skin. People totally reliant on staff to support them with their nutritional needs were at risk of malnutrition and dehydration, because of the lack of managing and monitoring their specific care and support needs. People's personal care needs were not met or managed; people were left in an unclean, unhygienic state. People were being physically restrained, care was provided against their will, and their care was not monitored or managed. The provider and the registered manager had not identified that people were not receiving their care as planned because quality and auditing systems were not effective in identifying concerns, delays or omissions in the care delivery.

People's nutritional needs were not managed effectively. People were not supported with parenteral feeding at the times it was required. People prescribed food supplements were not encouraged or supported to consume them. People were at risk of malnutrition, dehydration, weight loss and ill health due to the lack of monitoring and supervision of staff working practice. The provider and the registered manager were not monitoring people's nutritional requirements, therefore action was not taken and people were at risk of harm to their health, safety and wellbeing.

Staff told us they received the necessary training for them to do their job and to provide care and support to people. This is contrary to our observations. In terms of safe moving and handling, we observed poor moving and handling techniques being used. People experienced injuries and were at risk of further harm due to the inappropriate and unsafe manoeuvres utilised. The provider and the registered manager were not monitoring staffs' understanding and competency following the training.

Staff did not show an understanding of the Mental Capacity Act 2005, and the lawful and safe use of restraint practices. People did not always consent to their care and treatment, we saw physical and mechanical restraints were used. The provider was not following the principles of the MCA it was not consistently and effectively followed to ensure people who lacked capacity to consent were provided with care that was in their best interests and in the least restrictive way. This meant the provider and the registered manager did not understand their responsibilities associated with the Act.

Medicines were not managed or administered safely. We saw that issues with a nurse's competency and poor medication practices had been identified and action was documented for when and how the improvements needed to be made. We saw similar issues were on-going with the nurse's practices. People

did not receive their prescribed medicines when they were needed, some medication was given incorrectly contrary to the prescribing instructions and some people were administered medicines that had not been prescribed for them. People were at risk of receiving medicines in an unsafe and unreliable way. This showed effective action was not taken to correct safety issues to ensure medicines were managed safely.

People were at risk of receiving poor quality and unsafe care, support and treatment because of the lack of suitably qualified, trained and supervised staff. There was an extreme risk to people's safety, health and wellbeing because staff were levels were insufficient. The registered manager told us that the dependency needs of people were not an indicator or determinant for the staffing levels. The registered manager had been told by the provider the minimum levels would be maintained and would remain the same even when the service was at full capacity. This meant the provider and registered manager did not effectively assess, monitor or maintain safe staffing levels. Staff were not trained or suitably supervised to ensure they provided safe and effective care. There was a lack of leadership, the nurses and senior staff were not in sufficient numbers to supervise, monitor and guide staff to ensure good care and support was provided. There was a failure to assess, monitor and mitigate the risks this presented to people, in terms of safety and welfare by ensuring there were sufficient staff to meet the assessed needs of service users. This exposed people who used the service to the risk of harm and actual harm.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The service was failing to ensure people using a service have care or treatment that is personalised specifically for them.

The enforcement action we took:

We removed Sister Dora Nursing Home from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The service was failing to ensure people using the service are treated with respect and dignity at all times while they are receiving care and treatment.

The enforcement action we took:

We removed Sister Dora Nursing Home from the provider's registration.

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 service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

The enforcement action we took:

We removed Sister Dora Nursing Home from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	The provider did not have systems and processes established and operating effectively to act, report or refer immediately upon becoming aware of, any allegation or evidence of abuse

The enforcement action we took:

We removed Sister Dora Nursing Home from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The service was failing to make sure that people who use services have adequate nutrition and hydration to sustain life and good health and reduce the risks of malnutrition and dehydration while they receive care and treatment.

The enforcement action we took:

We removed Sister Dora Nursing Home from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The service was failing to make sure that people can make a complaint about their care and treatment

The enforcement action we took:

We removed Sister Dora Nursing Home from 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	The provider did not have effective systems in place to monitor and improve the quality and safety of the service or systems to mitigate the risks relating to the health, safety and welfare of service users.

The enforcement action we took:

We removed Sister Dora Nursing Home from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider did not ensure persons employed by the service received training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

We removed Sister Dora Nursing Home from the provider's registration.