Mr & Mrs R M Parkhouse

Garston Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 11 February and 8, 11 and 15 March 2016 and was unannounced. The inspection continued over several weeks because of the level of on-going concerns and to inform regulatory decisions about the next steps. We brought the inspection forward due to concerns raised in relation to people's care and welfare. At a previous inspection, in October 2014, the service was rated "inadequate". In July 2015 the home was rated as "requires improvement" after improvements were made. Evidence gathered during this inspection shows the service has not been able to maintain these improvements as ten breaches of regulations were found.

On 25 February 2016, a multi-agency safeguarding meeting was held. As part of that a plan was agreed with the provider, health and social care professionals, to protect people's safety and wellbeing. This included health professionals visiting the home every day as part of a support and protection role. The local authority quality improvement team are working with the home to help support improvement. We shared our concerns with the providers and with the safeguarding and commissioning teams during the inspection.

Garston Manor Nursing Home is registered to provide nursing care and support to 26 people who are living with dementia, mental health needs, and/or physical disability. 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.

People were not safe and were placed at risk of harm and abuse. Where abuse was suspected, the provider had not taken appropriate action to protect people, in line with their safeguarding policy. Where safeguarding incidents had taken place, the provider had not notified the local authority safeguarding team or asked for support or advice.

Risks to people's physical health were not identified and managed. The management of diabetes, choking, skin and pressure area care, and moving and handling was unsafe. Poor monitoring and management of people's eating and drinking put some people at risk. Care plans were not clear and up-to-date, which meant staff did not have information on how to meet people's needs. This meant people were at risk of receiving inconsistent care and not receiving the care and support they needed.

People were seen by GPs who visited the service regularly. However staff did not always make referrals to other healthcare professionals to ensure people's care and treatment remained safe. Since the safeguarding process started in the service, all relevant healthcare professionals have been involved. Records relating to the administration of medicines were not always clear.

None of the people living in the home had capacity to make their own decisions in relation to their care. Care files contained capacity assessments. There was some evidence the service had thought about

people's needs and relatives had been involved in making best interest decisions. However, some assessments were basic. Where staff were keeping one person in bed, no assessment or decision had been made in relation to this, to ensure it was in the person's best interests.

People did not always benefit from staff who showed kindness, respect, and compassion. There was a lack of consistency in the caring approach of staff. People were not always at the centre of the care they received because staff focused on the task, rather than the individuals. When people became anxious and distressed, some staff did not respond appropriately to reduce the person's anxiety. Most of the time during the day people were asleep, looking around the lounge, or walking around. There was little attempt to engage any of the people with any form of activity or conversation. At other times, we saw some caring and pleasant interactions from staff but these were limited to when care was carried out.

By the third and fourth days of our inspection, the provider had increased staffing levels. We observed staff had time to meet people's basic care needs but not to spend time with people. The provider did not have a system for determining how many care staff were needed in relation to the number of people who lived in the home and their dependency needs. This meant people were at risk of not having their needs met.

People were at risk of receiving care from unsuitable staff as recruitment processes were not robust. Staff had not been given appropriate training to ensure they had the skills and knowledge to meet people's needs effectively. Our observations of poor practice showed staff were not provided with suitable supervision or monitoring to ensure they met people's needs effectively.

The environment was not suitably adapted for people with dementia. The deputy manager said he had assessed the environment using a recognised dementia care assessment tool last year. However, we saw there had been little improvement since our inspection in July 2015. The premises were not free from offensive odours. Odours of urine were noted at different places and different points of the inspection, in some bedrooms and communal areas. People were not protected from the prevention and control of infection. The service did not maintain and follow good practice policies in line with current national guidance on infection control. Equipment including hoists and lifts had been regularly serviced.

The provider had a quality assurance system in place. However, this system was not effective as it had not identified the risks and issues we found during our inspection.

We saw some good practice. Although people, due to their dementia, were not able to tell us how they felt about staff or living at the home. We observed people responding positively to some staff. People's relatives told us they were happy with the care. Comments included "very happy – they feed her and keep her clean";" They are good at everything here" and "I am thoroughly happy". The service sought feedback from people, their relatives and visiting professionals. The results of the survey sent out in January 2016 showed there was a high level of satisfaction.

During the inspection, we identified a number of concerns about the care, safety and welfare of people who lived at Garston Manor Nursing Home. We found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have shared our concerns with commissioners, the safeguarding team, and the local authority food and safety team. People's care needs are currently being reviewed by the local authority commissioners.

We are taking further action in relation to this provider and will report on this when it is completed. The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by

CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Services placed in special measures will be inspected again within six months.
• The service will be kept under review and if needed could be escalated to urgent enforcement action.

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 safe and were placed at risk of additional harm and abuse because safeguarding concerns were not managed appropriately.

Risks to people's physical health were not identified and managed. The management of diabetes, choking, skin and pressure area care, and moving and handling was unsafe.

People were at risk of not having their needs met, as there was no system for determining how many care staff were needed in relation to the number of people who lived in the home and their dependency needs. There were times when staff struggled to meet people's basic needs.

People were at risk of receiving care from unsuitable staff as recruitment processes were not robust.

People were not protected by the prevention and control of infection. The service did not maintain and follow policies in line with current national guidance.

Systems for the management of medicines were not safe. Records relating to the administration of medicines were not always clear.

Is the service effective?

Inadequate

The service was not effective.

Poor monitoring and management of people's eating and drinking put some people at risk.

Staff had not been given appropriate training to ensure they had the skills and knowledge to meet people's needs effectively.

Staff had not received supervision for some time. The system for ensuring staff had the skills and competencies needed was not robust. Our observations of poor practice showed staff were not provided with suitable supervision or monitoring to ensure they

met people's needs effectively.

Where people could not make their own decisions, care files contained capacity assessments. However, these were basic and there were no additional assessments and best interests decisions based on the individual.

The environment was not suitably adapted for people with dementia.

Is the service caring?

Requires Improvement

The service was not caring.

Some staff treated people with respect and kindness but others did not explain things clearly to people or respond to their needs and anxiety.

People did not always receive the care they needed. Some people's dignity was compromised.

Staff routines took priority over the wellbeing and needs of the people who lived in the home.

Is the service responsive?

Inadequate

The service was not responsive.

Paper care plans were out of date and contained conflicting information. The computerised system did not have an up to date care plan for each person. Staff did not have clear information on how to meet people's needs.

Computerised care plans were not personalised. They did not contain the person's past history, preferences or interests, or specific information about their care needs.

People were not always at the centre of the care they received because staff focused on the task, rather than the individuals.

People didn't have meaningful activities or engagement and were not supported to live fulfilled lives.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had a quality assurance system in place. However, this system was not effective as it had not identified the risks and

issues we found during our inspection.

The culture was not always open and transparent. The registered manager had not handled safeguarding concerns in an open, transparent and objective way.

There was no system in place to ensure staff received supervision regularly. Outcomes for people living in the home were poor at times, as the registered manager had not developed the staff team to ensure they displayed the right values and behaviours towards people.

Garston Manor 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was brought forward because we had received concerns.

This inspection took place on 22 February and on 8, 11, and 15 March 2016. The first and second days were unannounced. The third and fourth days were announced. The inspection team included six inspectors.

Before the inspection we had received concerns relating to the health and welfare of people using the service. We reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider.

We met all of the people who lived in the service; most of them were living with dementia and were unable to communicate their experience of living at the home in detail. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with nine relatives.

We went into all rooms and areas in the home. We spoke with the registered provider, the registered manager, the deputy manager, seven staff, and eight visiting health care professionals.

We observed the interactions between staff and people living at the home and reviewed a number of records. The records we looked at included five people's care plans, the provider's quality assurance system, policies and procedures, six staff files, training files, accident and incident reports, records relating to medicine administration and staffing rota.

Inadequate

Is the service safe?

Our findings

People were not safe and were placed at risk of harm. Safeguarding concerns were not always reported or managed appropriately; action was not taken to protect people from the actions of others; risks to people's health were not managed; systems for preventing the spread of infection were not robust; medicines were not well managed; there were not always sufficient or competent staff on duty to meet people's needs; and staff recruitment was not robust. The local authority safeguarding team shared concerns with us about the safety of people before our inspection.

Where abuse was suspected, the provider did not take appropriate action. For example, the provider was made aware of allegations of abuse involving a staff member. They told us they had followed their internal policy. The service's safeguarding policy stated "allegations of misconduct against an individual will normally result in an immediate suspension of that person from duty pending an investigation of the allegations". However, we found the staff member had not been suspended and was on duty on the second, third and fourth days of our inspection. Following our inspection, the provider sent us their completed investigation. This confirmed that another staff member had witnessed inappropriate conduct. This meant there was eight days between the alert and the suspension of the staff member. This lack of action had placed people at risk of abuse.

Where incidents had taken place, the provider had not notified the local authority safeguarding team. For example, records showed there were a number of episodes when one person had become distressed and had hit out at others or were hit by others due to their shouting. Care records stated, "(name) was shouting and swearing at another female client and then a male client got up and smacked him around the face" and "during this episode they hurt others". Following these incidents, the person's care plan had not been reviewed and updated. The service had not made referrals to the mental health team. We found evidence of a further two incidents which had not been reported to the safeguarding authority. This included one person going missing, and one person who had bruises on their arm. This meant the provider had not worked with the safeguarding team to develop risk assessments and plans to ensure people were protected from risk of harm.

Staff's awareness of safeguarding was variable. One staff member was able to tell us about the types of abuse, and how they would respond if they saw or suspected abuse. However another staff member had no real understanding and told us the purpose of safeguarding was to respect people's privacy and dignity. We sampled staff files and found only three out of five staff had completed safeguarding training. The training matrix did not show any planned 'abuse awareness' training.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Risks were not managed to ensure people were kept safe.

A number of people who lived in the home had diabetes. Care records did not evidence how people were being supported to maintain a safe blood glucose level or whether staff were following the service's protocol

for responding to low blood glucose levels. For example, one person's care records showed their blood sugar levels to be unstable. There was no evidence staff were responding appropriately when this person's blood glucose levels fell below normal levels. Information about how the nurse had responded to low blood glucose levels and whether they had provided this person with anything to eat, to help raise their blood sugar, were not always recorded. There was no record of any food, sugary drinks or sweets being provided. Records did not always confirm the person had their blood glucose level checked. When it was checked, the result was not always recorded. The service used the local NHS diabetes management protocol. It provided descriptions of low blood sugar and the action to take. This stated "give a glass of energy or sugary drink, three or more glucose tablets or five sweets such as jelly babies, give glass or carton of fruit juice" and for the blood glucose levels to be checked again. Staff had failed to follow the protocol placing people at risk from the danger of having a very low blood sugar level. A community healthcare professional visited this person and reviewed their care. They also raised concerns in relation to unsafe diabetes management. The local authority who commissioned the service were concerned about the staff's ability to manage this person's diabetes safely, which resulted in them being moved out of the service.

We looked at how staff managed two people's skin and pressure area care. One person's care plan identified them as at a high risk of developing a pressure ulcer. Their care plan stated, "(name) skin is very delicate and frail" and skin seems to tear at the least pressure, it takes a long time to heal". This person's moving and handling plan guided staff to change this person's position every two hours and prescribed creams were to be applied twice a day. Records showed this person's position was not being changed as identified in their care plan, nor were the prescribed creams being applied as directed. For example, over an eight day period from 17 to 24 February 2016, care records showed that cream was only applied on five out of sixteen occasions. Visiting healthcare professionals told us this person had a broken area of skin on their buttock. A second person was also at risk of developing pressure ulcers. There was no care plan regarding pressure care for this person available on their electronic record. This person also had a written care plan. Staff told us they did not have time to access the written care plans which were kept separately in the office. Records showed this person's position was not being changed and their pad was not being changed frequently. We observed this person was not repositioned, moved or toileted over a period of three and a quarter hours. We gave feedback to the provider and asked them to take action to ensure this person's needs were met. By the fourth day of our inspection, this person had developed a grade three pressure ulcer.

One person's care plan stated they had swallowing difficulties and were at risk of choking. The care plan stated that the person was at risk of aspiration as they talked whilst eating. There was a brief description of what to look out for in aspiration, such as coughing difficulty. The advice was to give cola or gassy drinks which would bring up anything stuck in their throat and that a can of drink was usually kept in the manager's fridge. This is not a safe management method. The nurse on duty told us that she had noticed this person had some swallowing difficulties. Staff had not made a referral to a speech and language therapist (SALT) for advice. One staff member was not aware that anyone was at risk of choking. As there was no clear guidance in relation to the person's swallowing, staff were making their own judgements about whether to give them thickened fluids or not. Some days this person was given normal fluids and other days thickened fluids. This meant the person was placed at risk due to the lack of information and unsafe management of the risk of choking.

One person was identified as being at a high risk of falls. Records showed she had had several falls. One recent fall had resulted in an injury. The risk assessment said "although (name) is able to move around by themself, they are at a very high risk of falls". The written care plan stated, "(name) is very unsteady on their feet at times, forgets to use their frame putting them at risk of falls, causing possible injury to them self and others around them. Staff to remain vigilant, ensure (name) has their frame and observe closely in order to reduce the risk of an accident". We saw this person walking about the home with and without her frame. At

times, staff were present in the communal areas; at other times there were no staff present. We spoke with the registered manager who told us they had not made a referral to the community falls team for advice to see whether anything else could be done to prevent this person from falling or to protect them if they did fall.

Some people required assistance from staff with their mobility. The safety of these manoeuvres was variable. We observed staff assisting people with the use of a hoist. This was done safely with two members of staff who explained to the person what was happening. However we also observed people being assisted to stand from and to sit down in to a chair. The manner in which staff assisted people was unsafe. We saw staff pull people up from under their arms or guide them with a hand on their back. This placed people and staff at risk of injury. We brought this to the attention of the provider, and on the third day of the inspection, we saw staff assisting people more safely. However on the fourth day of the inspection, we again observed staff using an unsafe technique.

This showed that where risks were identified, the provider did not take sufficient action to ensure care and treatment was provided in a safe way, and that identified risks were being mitigated or managed.

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

People living in Garston Manor Nursing home had a high level of care needs. Their dementia meant that very few were able to express their views or wishes in a clear way. People also had a high level of physical dependence on staff to meet their needs. For example, six people needed assistance from two staff with hoisting. Eight people needed assistance to eat. At least eight people needed assistance to drink. Only twelve people could mobilise independently or with a frame. The registered manager told us they had had difficulty with recruitment and this had impacted on staffing levels.

We observed times when it felt particularly strained. These included mealtimes, mornings when people were getting up and having their personal care attended to, and in the evening when people wanted to go to bed. People's needs and requests were not always being met. For example, during our observation on the first evening, one person asked for a sandwich and they had still not received this when we left two hours later. We asked the nurse if she could check one person's continence pad. She told us two staff needed to support this person so it would have to wait. This person had not been checked when we left two hours later. This information was given to the provider so they could take action.

Staff told us that they needed at least two care staff upstairs and two care staff downstairs to meet people's needs in a timely way. All staff we spoke with said more staff were needed. One relative commented that staff were "sometimes stretched". We observed staff sometimes had time to meet people's basic care needs but not to spend time with people. When we arrived on the second day of the inspection, there were three members of care staff on duty, and the registered manager, who was also the nurse on duty. The two night care staff stayed on after they had finished their shift at 08.30am until at least 10:30am to assist people with their personal care. This meant there were more staff on duty to help get people up. Despite this, some people were still getting up into the late morning and having their breakfast. Lunch was then offered at about 1.00pm. This meant people were not able to space their meals throughout the day.

By the third and fourth days of our inspection, the provider had increased staffing levels. There were four care staff on duty and a nurse, as well as the cook, housekeeping and laundry staff. The deputy manager and provider were also present. Rotas for the week commencing 14 March 2016, showed the registered manager worked every day and as the nurse on two of these days. One deputy manager was on duty each day from Tuesday to Sunday. The other deputy manager worked each day from Wednesday to Sunday.

There were four care staff on each day which included one member of agency staff. Overnight, the nurse worked from 8.00pm to 7.30am supported by two care staff who worked from 8.30pm to 7.30am. The registered manager told us their ideal staffing level was four care staff and one nurse during the day, and two care staff and one nurse overnight. However, the provider did not have a system for determining how many care staff were needed in relation to the number of people who lived in the home and their dependency needs.
This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A new member of staff had been appointed to undertake the laundry and bed making duties. One member of care staff told us they now had more time to assist people as they no longer had to undertake laundry and bed making. The provider had recently recruited an activities coordinator who had not yet started work. A new deputy manager was due to start the day after our inspection.

The provider did not operate robust recruitment procedures. We looked at six staff files. Two out of six files had gaps in staff's employment history. Interview notes were not kept in any of the files. The registered manager told us they did not use formal questioning during interviews and they could tell if potential staff were suitable. Where an issue had been identified on one staff member's criminal record check, there was no evidence of any risk assessment having been carried out in relation to this. Two staff files did not contain any references. A further two staff members had started employment before their references were received. Three out of these four staff had worked in health and social care before, so this information was required by law. This meant the provider was not operating an effective and safe recruitment procedure for staff.

This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Prior to our inspection, an incident had occurred where a person with dementia had left the service unnoticed and was missing for two hours. The provider sent us a notification which said there would be increased activity and monitoring to ensure the person's safety as well as an extra lock on the front door. On the first evening of inspection, this person went through the back door to the laundry several times. The alarm sounded and care staff went to find the person. During the rest of the inspection, we saw that the alarm on the back door to the laundry was not sounding, allowing direct access to the outside semi-covered yard area and the laundry. On one occasion, we found another person in the back yard area next to the door of the laundry. The laundry door was wide open and no staff were present. There was an iron and ironing board out in the laundry which may have placed the person at risk of burns or trips. We walked back with the person to the lounge area and alerted staff. The lack of security arrangements did not ensure people were safe, and placed them at potential risk of harm.

People did not benefit from a clean environment. The premises were not free from offensive odours. Odours of urine were noted at different places and different points of the inspection, in some bedrooms and communal areas. One of the sofas in the lounge smelt of urine on each day of our inspection. On one occasion, we saw, what appeared to be faeces smeared on the side of one of the beds. This was cleaned after inspectors made staff aware. Some equipment was not suitable for people living with dementia. For example, in one dining room chairs were transparent. During our inspection, the provider and a CQC inspector tripped over them because they were not clearly visible. This presents a hazard for people who live in the home, some of whom are already at risk of falls, and to visitors and staff

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not protected by the prevention and control of infection. The service did not maintain and follow policies in line with current national guidance. There were gloves, aprons and small plastic bags for

soiled incontinence aids in the bathrooms. However, none were kept in people's bedrooms and there were no paper hand towels in the bedrooms of those people being cared for in bed. We asked staff how they washed their hands after they have finished assisting people with their personal care. They said they washed their hands in the communal bathrooms. Staff were seen wearing aprons and gloves when taking people's laundry from their room. A trolley with a laundry bag designed for soiled laundry was placed outside the bedrooms. However the laundry was placed directly into the bag without first being placed in a sealed water-soluble bag to reduce the spread of infection when soiled laundry was taken to and from the bag. The home's infection control policy did not contain information on how staff should handle soiled or contaminated linen. We saw a yellow bin which was full of incontinence pads. These had not been bagged separately. We observed a nurse giving medicines out in the lounge; she gave one person his medicines by putting them directly into his mouth with her fingers, not wearing gloves. We were told that everyone had their own sling for hoisting, but we saw the same sling being used for two people.

Systems for the management of medicines were not safe. Staff administered everyone's medicines. Records relating to the administration of 'when required' medicines were not always clear as those given outside of the normal round times were not clearly recorded on the Medication Administration Record Sheets (MAR). The home's protocol for 'when required' medicines stated, "the exact time of administration must be recorded to enable a carer to decide if the appropriate time period has passed before administering the next dose". The reason 'when required' medicines were given was recorded on the reverse of one person's MAR sheet but not on others nor was the exact time they were given. For those people who had 'when required' pain relief, there was a record of administration on the hand held electronic device but not a reason why it was needed or whether it had been effective. One person was prescribed medicine for anxiety and distress. There was no written protocol about when to administer this. The nurse said just when they were "very agitated", meaning staff would decide what degree of agitation would result in medication being administered. The administration of topical creams was not recorded on the MAR sheets. Staff told us they were given information about people who needed creams at handover. We asked them to show us on the hand held device who had creams and they were not able to. We reviewed the creams for one person and they had not been applied as directed twice a day. This meant staff could not be sure that creams had been applied regularly and this placed people at risk of skin breakdown.

Issues relating to infection control and medicines was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's medicine records contained a photograph of each person for identification purposes. Important information such as allergies or insulin dependency was highlighted. MARs were fully completed with no gaps. There were clear records to show quantities of medicines received at the service and when any had been returned. The local pharmacy had carried out a medicines review and recommended some weekly checks which had been put in place.

Equipment including hoists and lifts had been regularly serviced. There were gas and electrical safety certificates. There was evidence of legionella testing and of regular testing of hot water temperatures throughout the home. The fire alarms were tested weekly and there were regular fire drills.

Inadequate

Is the service effective?

Our findings

Care was not effective because people's needs relating to eating and drinking were not well managed; staff did not have the skills, knowledge or training to meet people's needs; people were not afforded their legal rights and the environment was not suitable for people with dementia.

Poor monitoring and management of people's eating put some people at risk. Monthly observations for five people showed they had all lost weight. For example, one person had lost 13kg between January 2015 and March 2016. We spoke with a visiting healthcare professional who told us despite this significant weight loss, no referral had been made to a SALT or dietician. Staff had last calculated the person's risk of malnutrition to be 'low' risk. The visiting healthcare professional rechecked this and found it to be 'high' risk. In February 2016, another person had been seen by the GP regarding weight loss. The nurse on duty was unable to tell us what advice was given and there was no evidence of any updated care plan. We spoke with the registered manager and deputy manager and they were not aware of people's weight loss. The service had not monitored and reviewed people's nutritional needs. There were no individual risk management plans in place to ensure people's nutritional needs were met.

People's hydration needs were not fully assessed, reviewed or met. Where people's fluid intake was being recorded, there was no information on how staff should support people to ensure they had appropriate and sufficient quantities of drink. For example, one person's care plan stated "(name) takes their fluids with thickener". There was no guidance about the consistency the drink should be thickened to. Individual hydration targets had only been set for one person living in the home, despite staff identifying other people as being at risk. The one person who had a target of 1800mls per day, received less than 1000mls on 14 days over a six week period. Records showed over a one week period this person was not offered anything to drink overnight. Amounts of fluid that people had drunk entered on fluid charts did not match the amounts entered on care records. Other people's fluid charts showed very low intake. For example one person who didn't have any verbal communication and couldn't ask for a drink had less than 500mls on 7 days out of 27 days. During our inspection, we received information from the local authority safeguarding team that people were visibly dehydrated when they went into the home. When we visited after this, fluid intake charts showed that people nursed in bed were getting more fluids than they had previously. We saw evidence that people were thirsty. For example, one person was in their room at 9.15am, waiting to get up. They were licking their lips and when we asked them if they were thirsty. They said "Very". We then saw them at 9.45am in the lounge sitting without a drink We asked them if they had had a drink yet and they said "no". We asked them when they had last had a drink and they said "before bed". We checked the hand held device and the last entry for a drink was at 8.00pm the previous evening. We asked what they would like to drink and they wanted water. We asked care staff to get this. They proceeded to drink three full beakers (approx. 280 ml each). The service did not have an effective system in place to ensure people received adequate hydration.

This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People who could speak, told us they enjoyed the meals provided by the home. They said they never went hungry and could have whatever they wanted. Many of the people we spoke with were not able to comment

about this. We saw people enjoyed a cooked breakfast each morning as well as a choice of cereals and toast. The service had recently employed a new chef. He was knowledgeable about people's dietary needs and was able to tell us how he catered for them on a day to day basis. He confirmed that senior staff updated him regularly regarding peoples preferences. The service offered a set main course each day. The chef told us if people wanted something else they could. However, we didn't see any evidence of alternatives being offered or provided during our inspection.

People had access to the GP who visited the service regularly. However staff did not always access other healthcare professionals to ensure people's care and treatment remained safe. For example, some people were in need of specialist advice regarding seating due to their physical frailty. However no referrals had been made to the occupational therapist service to arrange these assessments. We saw people sitting in chairs that were not designed to meet their needs.

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

Since the safeguarding process started in the service, all relevant healthcare professionals have been involved.

People who lived in the home had a range of needs. Staff did not have the skills and knowledge to meet these needs effectively. At our previous inspection in July 2015, the registered manager told us all staff were working towards the Care Certificate to ensure they had the skills they needed to meet people's needs. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. At this inspection, we found only 30% of staff had completed this. This course came with study books which need to be completed and assessed to ensure competency. In one staff file, we saw certificates of completion. However, the study books had not been marked or signed off by an assessor. This meant there was no evidence the staff member had been observed as competent in their job role.

Although some dementia training had been completed, we observed not all staff understood how to meet the needs of people living with dementia. Staff had not completed training in diabetes or continence care, despite there being people at the home who were living with these conditions. The training matrix showed gaps in training for fire, first aid, infection control, food hygiene, safeguarding and abuse awareness, and health and safety. We looked at the file for a staff member who started work at Garston Manor Nursing Home in July 2015. There was no evidence of induction training and the only recorded course completed was moving and handling. In a nurse's staff file, we did not find any certification in relation to specific nurse training and updates since their employment to demonstrate competency. We asked for evidence of nurse training but we did not receive it.

Staff received supervision. However, the system was not robust. Records were very brief. Staff files showed supervision had not taken place since November 2015. Our observations of poor practice showed staff were not provided with suitable supervision or monitoring to ensure they met people's needs effectively.

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

None of the people living in the home had capacity to make their own decisions in relation to their care. Staff sought consent on day to day decisions where people were able to respond. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular

decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Care files contained capacity assessments. There was evidence the service had thought about people's needs and relatives had been involved in making best interest decisions. However, we found that some of the areas of care such as continence and mobility only had basic assessments. There were no additional assessments and best interests decisions based on the individual. One person was spending a lot of time in bed. Staff told us that this was because of the difficulties of managing their movement and that they were kept in bed and frequently checked as "they can harm themselves". No assessment or best interest decision had been made in relation to this. This meant the decision had not been made in accordance with the Mental Capacity Act. The service could not demonstrate the decision to keep them in bed was made in the person's best interests.

On the second day of our inspection, we saw staff locking bedroom doors. Staff told us "they are all locked to stop (name of person) getting in". This restricted people's movement within their own home. The door locking continued on the third day of our inspection but stopped on the final day. The registered manager told us they were not aware this had happened.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made for all those living in the home.

The environment was not suitably adapted to meet the needs of individual's living at the home who were living with dementia. There was some 'dementia friendly' signage for toilets and bathrooms and brightly painted doors, but no significant adaptations for people living with dementia. The deputy manager said he had used an environmental tool last year and was working on improving the environment. However, we saw little improvement since our inspection in July 2015.

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People did not always benefit from staff who showed kindness, respect, and compassion. There was a lack of consistency in the caring approach of staff. Staff were busy and task focused; they didn't have time to sit with people for meaningful periods of time or focus on their wellbeing.

We saw examples of poor interactions between staff and people. During our observations, one person became anxious. He said "I want my wife". A staff member responded "she's not here" and walked away. He later asked another staff member "Where's my wife" and they responded "Where's your wife" and walked away. This did not recognise or reduce the person's anxiety, or demonstrate a caring and supportive approach. Later a different staff member sat down and spent some time with this person and they visibly brightened.

People's dignity was not respected or protected. On the first day of our inspection, we observed two people get up from their chairs. Their pads and trousers were so wet with urine they fell down. Staff took these people to their bedrooms to be changed. Seven out of fifteen people were wearing soiled clothing and looked unkempt. During the next days of the inspection, people's appearance had improved and they looked clean and tidy.

During our observations, most people who sought attention from staff received this. However, during one of our 45 minutes observations in the evening, different staff members came in and out of the lounge. We saw 10 out of 15 people had no interaction with staff, objects, or other people. When staff did interact with people, people responded positively and enjoyed this. People who did not seek attention were left for long periods just sitting and staring in the lounge with no input at all. One person showed signs of distress such as rocking and shouting but did not receive a response from care staff.

One person was transferred to a chair in the lounge. There was a brief but positive interaction. The staff member put their arm around the person's shoulder, talking softly with them. They passed them a doll toy which the person cuddled. Two hours later, the person had had no further interaction and was in the same position rubbing the arm of the chair.

Another person was in their bedroom and staff went into the room. We heard interactions were not unkind, but they were minimal and task centred. For example, a member of staff spent three minutes with the person giving them a drink. The interaction was focussed entirely on the task. At the end, the staff member said "all done?" The person responded "Yes – don't leave" but the staff member left them on their own.

Some people needed help to eat their meals. One person in the lounge had a bowl of food placed in front of them. The staff member sat down and didn't speak to them, and every now and then offered up a spoonful of food. The staff member was making entries onto the hand held device the whole time they were supporting the person to eat. Another staff member was helping someone in the dining room. They stood next to them as there was nowhere for them to sit. This did not show respect for people or give them a positive mealtime experience.

This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We also saw some people being assisted in their rooms, we saw staff sit down to be at the same level, and they were engaging people in pleasant conversation while assisting them.

Staff respected people's privacy by knocking on doors before entering their rooms. Where rooms were shared, curtains were in place and could be closed when personal care took place.

Due to their dementia, people were not able to tell us verbally how they felt about staff or living at the home, but we observed people responding positively to some staff and smiling. One lady saw a male member of staff approaching and walked towards him smiling, saying "here he is, here's my boy". He greeted her by name and responded with touch and a smile. When one person was crying in the lounge, a staff member went to them and put their arm around the person. They comforted the person, and chatted with humour and fondness. They walked away with the person gently at their own pace. The same staff member assisted another person with their frame their own pace, told them what was happening, chatted and offered them a blanket for their knees.

People's relatives told us they were happy with the care. Comments included ""very happy – they feed her and keep her clean" ; " They are good at everything here" and "I am thoroughly happy".

We saw some caring and pleasant interactions from staff but these were during care tasks such as asking to go to the toilet, walking with people to the dining room, and providing drinks, rather than social interaction. During the delivery of the care, some staff were chatting and laughing with people. We did not see staff sitting and spending time with people. One member of staff, spent quite a lot of time talking to one person to encourage them to change their clothes before lunch. They were quiet and patient with them. The same staff member helped with a transfer between wheelchair and chair and spoke with the person throughout: "that's it, you are doing really well, take your time".

People's level of dementia was such that involvement in decisions about their care would be difficult. Relatives we spoke with all felt that they were appropriately consulted and involved in reviews. They said they were kept informed and felt involved with what was happening.

Inadequate

Is the service responsive?

Our findings

The service was not responsive because people did not receive consistent and personalised care, treatment, and support; staff did not have the information they needed to support people appropriately; people did not have access to person centred activities and were not encouraged to maintain their hobbies and interests.

The service had paper care plans and had introduced an electronic care plan system which was available on a computer, and on hand held devices. Staff who had worked at the service for some time knew people's behaviours and preferences but told us they didn't have time to access the care plans. The paper care plans contained more detailed information about each person but had not been reviewed since September 2015, when the service moved over to the hand held device system.

The computerised system did not contain up to date care plans for each person. The paper care plans were out of date and gave conflicting information. For example, one person's mobility plan said they were mobile with the assistance of one staff member and close supervision. Their pressure and skin management care plan said they should "be encouraged and assisted to take exercise every 2 hours and walk from one side of the dining room to the other". At the time of our inspection, this person was not mobile.

Another person's care plan was generated by the computer. It consisted of a tick box "Independent Living Skills Assessment" which identified whether the person needed assistance. No personalised information was recorded. For example, their cognition assessment stated "I will often resist care provided and need substantial reassurance from staff". There was no description about what this person found reassuring, how living with dementia affected their daily living, or what strategies staff should adopt to support them.

The results of the assessments created the care plan, which contained pre-written statements, it was not personalised in any way. For example, there was no past history about the person, no preferences or interests, no specific information about their care needs. There was no evidence the person or their representatives had been involved in the care planning. There was no information about the strengths and abilities the person had and how to retain those. This meant staff did not have the information to encourage and promote this person's independence.

One person's care plan had conflicting advice about diabetes management. One file stated "monitor blood glucose levels weekly" but the care plan file stated monitoring was no longer required unless "looking or feeling unwell". This person was living with dementia and had very limited communication skills; they would not be able to say if they felt unwell. The nurse was unable to find any information about when this decision was made. The new computerised system did not have any function that allowed staff to see GP or other visiting professionals input easily.

The lack of an accurate care planning information meant people were at risk of inconsistent care or not receiving the care and support they needed.

People were not always at the centre of the care received because staff focused on the task, rather than the

individuals. Night staff were delegated work and responsibilities for getting ten people up and bathing people before day staff came on duty. Due to the number of staff on duty and the time it took to get people up, people could not get up in a timely manner. People were still getting up late into the morning. People were not offered breakfast or a drink until they were taken through into the lounge for breakfast or, if nursed in bed, were having their morning personal care needs met. We saw evidence from care records that some people were going to bed very late, in some cases after 2.00am. These people wouldn't be able to express their wishes or choice about their care and there was no record of their preferences in their care plan. We received information that people went to bed late as staff didn't have time to get them to bed earlier. This demonstrated people's care was not based on their individual needs and preferences.

Most people spent their day in the main lounge during the day. This room could get very hot, even with the majority of the sun blinds closed. Most of the time people were asleep, looking round the room, or walking around. There was no attempt to engage any of the people with any form of activity or conversation. Staff interacted with people when they were carrying out specific tasks. For example, assisting people to the bathroom or offering drinks.

People did not benefit from activities or engagement that had been designed to address issues such as preventing isolation, helping to maintain the person's identity, and helping the person feel valued, helpful and involved. There was no evidence people had been supported to follow their individual interests. Some people had developed friendships with the people they lived with. For example, two people walked around together holding hands. There was an activities calendar in the lounge. However what we saw during our inspection did not reflect this. On the afternoon of our second day we saw a staff member lead a sing-a-long. About five people sat around but the staff member didn't know the words to the song, therefore people were not fully engaged with the activity. Staff acknowledged that the staffing levels were such that they were not providing activities themselves. There were a few weekly events that came in from outside, such as craft, a guitar player, and somebody that came into provide a physical activity session.

There were dolls, soft toys and books in one corner of the lounge room. We discussed with staff making these more accessible to people and having more points of interest and more meaningful engagement for people.

Despite the management acknowledging this was an area that needed to be developed at our previous inspection, people still didn't have opportunities for meaningful activities or engagement, based on their individual wishes and choices.

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

People's relatives felt able to raise concerns if they needed to, but told us they didn't have any. Where complaints had been received, these had been investigated. There was a box in the reception area for visitors to post any concerns.

Inadequate

Is the service well-led?

Our findings

Garston Manor Nursing Home has not been able to meet the CQC regulations over a sustained period. Over eight inspections, carried out between 2012 and 2016, the service has only met all of the regulations inspected on three occasions. In October 2014, the service was rated "inadequate" and the local authority quality monitoring team worked with the provider and staff to support them to bring about improvements. In July 2015 the home was rated as "requires improvement" after improvements were made. Evidence gathered during this inspection shows the service has not been able to maintain these improvements as ten breaches of regulations were found. During this inspection we have found people were not receiving a safe, effective, responsive, or well-led caring service.

We have shared our concerns with commissioners and the safeguarding team. On 25 February 2016, a multi-agency safeguarding meeting was held. As part of that a plan was put in place, with the agreement of the provider, health and social care professionals, to protect people's safety and wellbeing. This included health professionals visiting the home every day in a support and protection role. People's care needs are currently being reviewed by the local authority commissioners. In addition, the local authority quality monitoring team are working with the provider and staff to support them to bring about improvements.

The service did not have a positive culture. Care was task orientated which meant people did not benefit from a personalised and empowering approach. The registered manager did not lead by example. There was a lack of oversight of the service which allowed poor practice and inconsistent care to be delivered. The registered manager was unaware of events relating to the care of people living in the home. When we fed back concerns, they did not take action to resolve the issues.

The culture at the home was not always open and transparent. At times, staff were reluctant to speak with us. The registered manager had not handled safeguarding concerns in an open, transparent and objective way. At a previous inspection in October 2014, we found the registered manager was not reporting safeguarding incidents appropriately. At that time, the registered manager assured us future safeguarding concerns would be reported. At this inspection, we found further evidence that safeguarding incidents were not being reported to the local authority safeguarding team. This shows the registered manager had not learnt from the previous breach of regulation to ensure this did not happen again.

Although the provider had a quality assurance system in place, this was not effective as it had not identified the risks and issues we found during our inspection.

Records relating to the care and treatment for each person were not accurate or up to date. The system for checking that people's needs were met on a daily basis was not robust. The new hand held device system was not operated effectively. On the first day of our inspection, the system showed there were 77 missed 'must do' events. The registered manager told us that sometimes people are asleep or decline, and staff are not filling in the system. The deputy manager told us they had put all care tasks on as a 'must do' and this had been unmanageable. We found these 'must do' tasks had been removed from the system by the second day of our inspection. The deputy manager told us he planned to review the tasks and put them back on the

system. In the meantime, there was no clear system in place to ensure people's needs were met.

The majority of people living at Garston Manor Nursing Home had nursing needs. Their care should be assessed and planned by a nurse. The care is delegated to care staff to deliver. The nurse has overall responsibility for ensuring that the care delegated is delivered safely and in the way it was intended. There was no system in place to make sure this happened. No-one held overall responsibility for ensuring people had received the care they needed. When we asked if specific care had been completed for one person, the nurse on duty did not know and said we would have to ask the care staff.

There was no system in place to ensure staff received supervision regularly and staff turnover at the service was high. The registered manager told us they had found it difficult to recruit and retain the right staff. The registered manager had not developed the staff team to ensure they displayed the right values and behaviours towards people. At times, this resulted in poor outcomes for people who lived in the home.

Records relating to staff were not complete. We had to ask the registered manager several times for one of the files. When we received it, we found important information, required to be obtained by law, was missing.

The home carried out monthly audits in the following areas with action plans: window safety, records, room temperatures, maintenance, privacy, staffing, outside areas, control of substances hazardous to health (COSHH), catering, care documentation, administration, housekeeping, safety and security of premises, and electrical safety. All audits were computerised and in a standard format, not personalised to Garston Manor Nursing Home. Issues had been identified by the audits and each area contained a separate action plan which identified any need for improvement. However these did not contain specific and detailed information on how improvements would be made. For example, the action plan related to pressure area risk assessment stated "high turnover of staff has required a focus back onto care certificate. Expectation for completion 01/01/16".

The service had received a food hygiene inspection in September 2015. The rating was five star which meant the service was maintaining a very good level of food hygiene. However, we asked to see a copy of the "Safer food, better business" records, which needed to be completed on a daily basis. The last entry in this book was in November 2015. Staff told us they had asked for more copies of the pages but hadn't received them. Many of the items contained within the fridge were not dated when opened or appropriately covered. This meant food may be used after it should have been disposed of, which also created a risk of cross contamination. We have shared our concerns with the local authority food and safety team.

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

The registered manager was also the provider of the service. Staff and relatives told us they found the registered manager approachable, felt able to talk with them and did not express any concerns. However during our inspection we observed the registered manager expressing exasperation to her staff, in the presence of people living in the home, in relation to the inspection. This clearly had an impact on people sitting in the lounge, we saw that people looked startled.

The service sought feedback from people, their relatives and visiting professionals. Annual surveys were sent out in January 2016. The results had been analysed and there were plans to share these with relatives. The surveys included people and their representatives, visitors, staff and professionals. They covered CQC's five key questions of safe, effective, caring, responsive and well-led. The results of the survey showed there was a high level of satisfaction. Feedback cards were also available by the signing in desk, next to a suggestion box. Relatives meeting were held to discuss what was happening at the service.