Ferns Nursing Home Limited

Ferns Nursing Home Limited

Inspection report

Ferns Nursing Home Limited
40-42 Part Street
Southport
Merseyside
PR8 1HY

Tel: 01704501401

Date of inspection visit:
25 February 2016
26 February 2016
02 March 2016

Date of publication:
10 August 2016

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

An unannounced focused inspection took place on 25 February 2016 to follow up on concerns from the previous inspection on 8 July 2015 which were related to people not having enough to drink, placing them at risk of dehydration. We found the rating was not displayed for members of the public to see and this was brought to the attention of the provider. Due to the level of concerns on the first day of our inspection we then proceeded with a full comprehensive inspection on 26 February 2016 and a follow up visit on 2 March 2016.

At the previous inspection there were breaches of Regulation 14 Hydration and 15 Premises and equipment identified and the service was rated as requires improvement. We found on inspection the service remained in breach of these regulations in addition to further breaches of regulation.

The service had also been previously rated Inadequate for two breaches of Regulation 12 Safe Care and Treatment and also Regulation 17 Governance in December 2014.

The service was a 33 bedded nursing care home. One of the stipulations of their registration was that they were required to have a Registered Manager to lead the service. The manager was in the process of registering at the time of our inspection to become the 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.'

Due to the level of concerns and the immediate breaches of Regulation 14 and 15 found on the first day of our inspection, we undertook a full comprehensive inspection.

We found the service was not keeping people safe from harm or abuse. One resident who was unable to communicate their needs requiring 24 hour nursing care was observed to have marks/bruises to their arms which had not been documented or investigated and there was no body map to illustrate where and when the mark/bruise was first seen. We were shown photographs taken by a family member of marks/bruises which had appeared since October 2015. We also found evidence the relative had made several complaints but the service failed to send a safeguarding to the Local Authority and failed to investigate all the complaints with an outcome.

There were not enough staff to meet the needs of the residents. We observed people who required assistance to eat and drink were not having adequate amounts of food and fluids. This was observed from the fluid balance charts and also by our observations of individual residents. For example, one resident's plate of food was cold as there were not enough staff to provide them with the support they needed to eat. We also observed one resident's water jug and beaker in their bedroom was dry to touch.

We were concerned the service did not have empathetic or skilled qualified staff to care for people with complex health needs such as dementia. One qualified nurse was observed to have retrospectively completed care records. Another nurse spoke disrespectfully about one resident and were not knowledgeable in the care of people with dementia despite there being a high number of residents suffering with dementia. We found the service did not offer staff dementia training. The manager was not skilled in implementing effective systems according to risks. We were also concerned that the manager was being restricted in their role by the owners who specified how many staff could be deployed despite them not being aware of all the complexities of the needs of the residents.

The residents care records were incomplete with risk assessments missing and also no Mental Capacity Assessments/Deprivation of Liberty Authorisations in place for people who were lacking in mental capacity. We questioned the practices of administering medication to people who lack mental capacity in the absence of a Best Interests Process being followed. One resident who lacked mental capacity was being administered medication by the nurse placing the medication on the person's tongue whilst the person opened their mouth to drink their thickened fluids. We discussed this with the nurse who had not considered their practice may be classed as covert administration of medication.

The Fire Service had inspected the premises a few weeks prior our inspection and rated the service as inadequate with an action plan to mitigate risks.

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.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Following the second day of our inspection we asked the service for an urgent action plan given the seriousness of the concerns we found. We followed this up on the third day of our inspection and found sufficient improvements had not been made. On 3 March 2016, the provider informed us of their decision to close the home voluntarily and cancel their registration. We worked closely with other stakeholders and all people who used the service were moved to other care homes within 7 days of the provider informing us of their intention. The registration of the provider is in the process of being cancelled.

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.

We found people were not being safeguarded appropriately when required and staff were not taking action to keep people safe.

Incidents were not always reported or thoroughly investigated to ensure people were being kept safe.

Staffing levels were inadequate with people suffering with dementia not being supervised adequately to ensure they were eating and drinking appropriate amounts.

Is the service effective?

Inadequate

The service was not effective.

People were not having adequate amounts of food or fluids.

There were seven people we observed to lack mental capacity who had not received a mental capacity assessment or Deprivation of Liberty Authorisation.

We could not see consent being sought from the care records we viewed.

People were accessing health care professionals according to the records we viewed but not in a timely manner.

Is the service caring?

Inadequate

The service was not caring.

People were not being treated with dignity and respect.

Staff did not have the time to sit and talk to residents and therefore, we were concerned people wishes were not known.

The care being provided was task focused.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving care when they needed it.

People were not receiving person centred care.

We found complaints had not always been investigated.

Is the service well-led?

Inadequate

The service was not well led.

The culture of the service was not person centred.

Systems were failing with no effective audits to highlight what the issues were.

The service was not being led effectively to learn from mistakes.

Ferns Nursing Home Limited

Detailed findings

Background to this inspection

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

This unannounced focused inspection took place on 25 February 2016 to follow up on concerns from the previous inspection on 8 July 2015 which were related to people not having enough to drink, placing them at risk of dehydration. We found the rating was not displayed for members of the public to see and this was brought to the attention of the provider. Due to the level of concerns on the first day of our inspection we then proceeded with a full comprehensive inspection on 26 February 2016 and a follow up visit on 2 March 2016.

The inspection team consisted of an adult social care inspector and a specialist nurse advisor.

We gathered information prior to our inspection and requested a Provider Information Return form be returned to us to provide us with information about the service. We did not receive a PIR form. We received concerns about the standard of care at the care home and there had been a number of safeguarding's over the past 12 months and a high number of complaints. We spoke to the safeguarding in the Local Authority, Health Watch and Continuing Health Care as part of our information gathering.

During the inspection we spoke with five residents and observed the care of 10 people who were unable to converse with us. We spoke with six relatives.

We looked at documentation such as care plans and fluid balance charts for 10 people. We case tracked high risk people who were unable to communicate or where concerns had been found on day one of our inspection. This involves undertaking a detailed check of information available for us to view from

admission and other information pertaining to the person encompassing all aspects of their care.

We viewed six staff recruitment files to check the appropriate checks were being undertaken prior to staff working at the care home. We spoke with a rage of staff of varying roles such as a cleaner, the cook, carers, qualified nurses, the manager and provider.

Inadequate

Is the service safe?

Our findings

At our last inspection we found the service was not always safe. Some areas for improvement of the environment including refurbishment were needed. Not all areas of the home were appropriately clean and staff were not following the required practices for infection control. People told us they felt rushed by staff sometimes and that some staff seemed too busy to support them appropriately with aspects of their personal care.

We found people were at risk of abuse due to the failing systems and complacency of the manager and staff to take action when needed. During our inspection we discussed with the manager and qualified nurses the importance of ensuring all bruising/marks that had appeared were recorded clearly with a body map to ensure a thorough account of when and subsequently how the bruise developed was investigated. We saw one resident had marks and bruises but there were no records to determine when or how they appeared. We read about concerns highlighted by the Local Authority Safeguarding Team of this nature whereby the service had previously failed to ensure that appropriate action had been taken by the service by ensuring body maps and documentation could explain an account of bruises. We were concerned about the manager's response and the staff's response when we discussed this with them. The manager and staff told us they did not consider it appropriate to complete a body map each time someone who bruises easily develops a bruise. Staff had not considered that this would place a person who bruises easily at higher risk of abuse. We therefore, concluded that there was a serious failure in the system to protect people from abuse and harm as not only did the service not demonstrate a clear procedure for documenting marks/bruises but the staff also told us they did not see the importance of always reporting and documenting new marks/bruising.

We spoke to the manager about the needs of people in order to ensure we were aware who may be able to converse with us and we were informed there was one person in the care home with a diagnosis of dementia. As part of our inspection we requested a list of people who lived at the homes room numbers to enable us to speak to people as we inspect the care home. We visited people who were nursed in bed in their rooms and found six, a high number of people in the care home suffering with dementia. We were concerned that in view of the manager not having a clear and thorough over view of all the residents this placed people at risk of their needs not being met, placing them at unnecessary risk of harm including a deprivation of liberty in the absence of a deprivation of liberty authorisation for people who lacked mental capacity.

The systems in place to report and investigate incidents were failing. We found one person who had an un-witnessed fall and banged their head had not received medical attention, a risk assessment had not been put in place following the fall thereby failing to ensure the service had thoroughly assessed how the fall occurred and mitigated the risk of the same incident reoccurring. We also found evidence of an incident which was documented in the communication book - "X was very aggressive - hit X in the throat with the call bell". We could not see any other information to confirm the service had ensured they investigated this incident as to why this occurred or undertook a risk assessment to mitigate the risk of an incident reoccurring.

This was a breach of Regulation 13 (1) (2) (3) (4) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative commented that they were concerned about the response times of the call bell during a relatives meeting and people can be waiting as long as 20 minutes until someone attends. We could not see a response from the manager regarding this concern. This was corroborated by another relative who raised this concern following our inspection. They told us they received a phone call from their relative who resided at the care home distressed as no one had responded to the call bell and by the time the relative arrived at the care home the person had been incontinent and was distressed. We looked at the staff rotas and found that the staff ratio dropped down in the afternoons from four carers in the mornings to two or three carers in the afternoons. We were informed there was an activities coordinator in the care home undertaking an activity for one hour each afternoon Monday to Friday in the day room. We ascertained that the activities coordinator was also providing care for people, had been assigned to providing drinks for people and we observed was also assisting with distribution of meals from the kitchen. We were concerned there were not adequate staffing levels and some staff were therefore, taking on numerous roles.

We observed people were not receiving care when they needed it. For example, we observed one person in the day room with a plate of food which had been placed in front of them. We observed the food was cold. We checked the person's care plan and it stated that the person needed assistance with eating and drinking. On another day of the inspection we observed another person who required assistance with eating and drinking scooping porridge with their hand to their mouth. We therefore, raised concern with the manager and the provider that the staffing numbers were not adequate to ensure that people were receiving the assistance they needed. We asked the manager how they assessed the staffing levels required to ensure all the care needs of the people living at the home were met. The manager told us the staffing levels were set by the provider and they did not change according to the changes in dependency levels of people. We could not see a system in place to assess the staffing levels required to meet the needs of people.

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

We viewed one care plan for a person who was admitted to the care home approximately three years previously and was nursed in bed, high risk for pressure areas developing. We saw their waterlow score had not been recorded on admission to the care home. A waterlow score is a scoring system which is used to ensure the risks for people developing pressure areas is identified. We found two waterlow scores dated 28 January 2015 with a score of 13 and 27 January 2016 a score of 24. This meant that the service had failed to carry out assessments in a timely way on admission and thereafter were failing to review the risks often enough to ensure they were doing all that could be done to mitigate risks of skin breakdown.

We also found the person who was at high risk of choking did not have a choking risk assessment in place and we found the documentation missing to demonstrate that a thorough oral hygiene programme had been followed. This meant that we found the oral hygiene being undertaken for the person was not adequate to ensure all the residue thickener was removed from their mouth to prevent foreign substances entering their airway. This can lead to lung infections thereby placing the person at extreme risk of harm or death. We read that the person was already at high risk of infections and had a chronic severe peridonitis which means an infection of the mouth. Therefore, we were concerned that the appropriate risk assessments were not in place for staff to mitigate risks and ensure people's health and wellbeing.

We viewed one person's care plan and found the care plan and risk assessments had not been completed. We did see a 'New Enquiry Form' which contained information about the person prior to admission to the

care home completed by the manager. We highlighted our concerns with the manager as to why the person did not have a care plan and risk assessments and we were informed it was because they had accepted the person into the care home on a Friday evening for the weekend for respite until a package of care could be put in place after the weekend so a care plan was not needed. We found the person had been in the care home for over a week. The manager was unaware that they had a responsibility to ensure they put a care plan/risk assessment in place for people who were admitted for short term respite. Therefore, we were concerned people were being placed at unnecessary risk as their care needs were not being clearly documented for staff to know what the person's care needs were and any risks. We subsequently found that the person had sustained a fall and an injury to their head with no falls risk assessment put in place following the fall. We were also concerned the service was not equipped to mitigate risks when they occurred.

We observed one qualified nurse administer medication on a medication round. The first person we visited was insulin dependent diabetic, it was explained to us by the nurse that the person's blood sugars were unstable. We went into the person's room and we observed the person had not eaten most of their lunch. We mentioned this to the nurse who suggested they had probably eaten a couple of packets of crisp. When we checked the care records we observed the resident was not on a food chart.

We also observed the nurse take a codeine phosphate tablet out of a blister pack, the nurse then realised the dosage had been changed from 30mgs to 15mgs this was documented on the Medication Administration Record (MAR). The nurse then took the correct dose from another pack of codeine phosphate with the person's name on it. The nurse left the blister pack on the trolley. The nurse administered the medication to the person but the nurse failed to prompt the person to take the medication. We then prompted the nurse regards the opened blister pack on the trolley and the nurse stated they would sort it out later upon completing the medication drugs round.

The qualified staff were not always following best practice or their code of conduct. We viewed a choking risk assessment compiled by a qualified nurse which was hand written and placed on the resident's wall. This was written following our concerns a risk assessment to mitigate risks of choking was absent for one resident who was high risk of choking. We raised concern that the risk assessment was unclear for staff to follow and was not referenced to demonstrated where the advice had been sought from to ensure it was following best practice. From what we found on inspection we were concerned about the lack of experience and skills of the qualified nurses observed and reported our concerns to the Nursing and Midwifery Council.

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

The care home underwent a Fire Safety Audit a few weeks prior to our inspection. We spoke to the fire officer who completed the audit. The fire officer confirmed the care home was rated inadequate and immediate action was requested to implement safe evacuation procedures. The fire officer requested remedial action over the next proceeding three months or an enforcement notice would be issued. The fire officer told us they had received confirmation that the service had ordered evacuation equipment. During our inspection we found fire doors were being propped open, some windows would not open for ventilation and equipment was being stored in inappropriate places such as corridors.

During our inspection we observed the cleanliness of the care home. We found there were soap dispensers void of liquid soap for people and staff to wash their hands. One toilet we viewed had dried faeces around the toilet pan and we found sections of the care home had an unpleasant odour. We observed a mop bucket with dirty water left in the corridor on the first floor.

The service were continuing to be in Breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At the previous inspection we found that accurate records were not being maintained to record when people who required assistance with their drinks and fluids had been supported to have them. The provider was therefore not able to demonstrate that people had been supported to have an adequate amount of fluids. Care staff had not been provided with Mental Capacity Training. Reference to people's mental capacity had been documented in their care plan but there was little detail to this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

The manager confirmed there were no Deprivation of Liberty Applications pending which had been sent to the Local Authority. We were unable to visit all of the people in the care home but we were able to observe seven people who had severe cognitive difficulties and were unable to communicate. Upon checking the documentation we found only one person had a Deprivation of Liberty Authorisation in place which was a person who we had not observed during our inspection. Therefore, people who were observed to lack mental capacity to make their own decisions and provide consent to remain at the care home to receive care were being detained unlawfully under the Mental Capacity Legislation. We discussed this with the manager and the provider who told us they were relying on the Local Authority to provide them with guidance as to which people required a mental capacity assessment and deprivation of liberty authorisation in place. The manager told us this was a matter they were aware needed addressing and told us they had not had an opportunity to address it due to them being in post a short duration since June 2015. Never the less, people were being deprived of their liberty which is unlawful.

This was a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For people who we saw who had dementia and were cared for in their rooms at all times, we did not find any evidence of dementia friendly tools such as memory boxes, familiar pictures or familiar music to provide stimulation. Some rooms had bare walls, thereby not providing adequate stimulation for people. We observed people were sitting around the outskirts of the room in the ground floor lounge with no opportunity for people to converse with one another if they wished to due to the distance of the chairs thereby preventing people from conversing with each other. When we asked the provider if they had ever arranged for dementia training from a dementia specialist advisor to advise staff how to provide an

appropriate environment and stimulation for people with dementia they said they hadn't in the past but would consider this for the future. Creating personalised bedroom environments for people with dementia with pictures of family members and personal belongings promotes a person's respect and dignity but it also assists staff caring for them to understand their background and personality in order for staff to care for them in the best way possible. People living with dementia can suffer a sense of loss, causing anxiety and therefore they often need an environment which provides them with comfort. The National Institute for Health and Care Excellence provide guidance regarding creating dementia friendly environments for people who suffer with dementia.

We viewed seven staff files and spoke to a range of staff to check if they had received an induction and training. We also made checks of the systems in place to ensure staff received regular supervision to ensure staff were receiving the support they required. One member of staff we spoke with told us they had not received an induction and said they had to learn 'on the job'. We checked staff files and found not all staff had received an induction. Staff supervisions were 'adhoc' with the last supervision seen in the staff files dated October 2015. We could not see a system of supervision and appraisal in place to ensure staff were being given the opportunity to speak to someone more senior about any concerns they may have and to ensure their training needs are identified as part of a development plan. This meant we could not be sure staff were up to date in their clinical practice to ensure people were receiving care based in best practice.

The manager told us there was a Training and Compliance Officer who was responsible for compiling the training matrix. We were provided with a training matrix to check the training received by staff so that we could be confident staff were skilled and competent to perform their caring tasks. According to the training matrix provided not all qualified nurses were up to date with moving and handling, safeguarding, mental capacity, medication, health and safety, infection control, fire safety, food hygiene or nutrition and hydration. One nurse' training was out of date for all training listed. Four nurses had not received nutrition and hydration training and three nurses were out of date for medication administration. Two nurses had not received up to date training regarding Mental Capacity and Deprivation of Liberty Safeguards. We were concerned there were a high number of people suffering with dementia and yet dementia training was not listed on the training offered to staff. We highlighted this to the provider who agreed to provide this for staff. We also checked the training provided to staff and found 19 out of 29 staff had not received up to date first aid training. The majority of staff had received up to date safeguarding training but 12 staff had not received nutrition and hydration training. We visited one person in their room who was nursed in bed and observed the persons bed was against the wall with no space for a manual hoist into the bedroom. On close inspection we found the person presented with marks which appeared consistent with manual handling marks where staff may have attempted to move the person. These marks were not documented. We were concerned staff were not all up to date with manual handling training and staff may not be following best practices to ensure they were moving people safely.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned people were not having enough to eat or drink. From the documentation we looked at for four residents with fluid balance charts in place, all had a low fluid intake between 500 – 700mls per 24 hour period. We observed one person's water jug and beaker were dry to the touch and when we checked the fluid balance chart they had not received any fluids since 9pm the evening prior to our inspection. This meant that the person had not been given anything to drink for a period of approximately 13 hours. The person told us they were very thirsty and we called the call bell. A carer then provided the person with a drink. We asked the person if they had eaten any breakfast and they told us they had not been given breakfast. We asked a carer about this and we were told the person did not eat breakfast. The person told us

they liked porridge for breakfast. Therefore, we concluded staff were not always aware what people liked to eat to ensure they were offering enough to eat. This meant people were at unnecessary risk of developing weight loss and secondary tissue viability problems. The carer told us they had not received any training in nutrition and hydration. We viewed other fluid balance charts and one person had not had a drink for approximately 18 hours from the documentation we viewed. We observed the person's water jug was not within their reach. One relative we spoke to during our inspection told us they were concerned their relative was not having enough fluids.

The provider told us they had allocated an additional staff member to specifically provide fluids for people but despite this we observed people were not receiving an adequate amount of fluids. The provider also told us they provided fresh fruit and vegetables for residents to eat. We spoke to the cook and checked the diet notification sheets in the kitchen for the cook to refer to when preparing food for people. We found the information on the sheets had not been reviewed since April and May 2015. Therefore, we could not be sure the information on the diet sheet was accurate to ensure people were being offered the appropriate foods to maintain their health and wellbeing. One person had a drink of tea on their locker out of their reach. We observed they were unable to feed or drink without assistance. They had turned the beaker upside down and it was all over the bed table. We contacted a carer to assist. Later in the afternoon we visited the same resident again. There was a beaker of tea left on their locker again out of their reach. This placed people at risk of dehydration, malnutrition and neglect.

The service were continuing to be in Breach of Regulation 14 (1) (2) (a) (b) (4) (a) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed entries in the documentary evidence we looked at where people had accessed health care professionals by way of visits to clinic or to hospitals. For example, one entry in the care records stated the person had been reviewed by the Speech and Language Therapist on 28 October 2014, 29 October 2014 and 14 March 2015. However, we found despite recommendations made by health professionals such as oral hygiene we did not view nursing records to confirm how often oral hygiene was being provided despite the resident being high risk of infection. We also did not see a care plan to provide specific instructions for staff to follow to assist with eating and drinking.

Inadequate

Is the service caring?

Our findings

At our previous inspection we found the service was not always caring. People described staff as 'caring' and 'good'. However, some people felt staff were not always understanding and supportive when they required support with aspects of their personal care.

We spoke to one nurse who described one person using a word which was both disrespectful and unprofessional. The nurse was asked for information as to what the person's diagnosis was and they responded - "reduced mobility". We found in the records that the person suffered with dementia and required support with eating and drinking. When we explained to the nurse we had seen the person sitting in a lounge in front of other people who lived at the home and in view of the doorway where people pass by, feeding themselves porridge with their hand, the nurse responded and told us the person sometimes liked to feed themselves with their hands. People with advanced dementia lose recognition of what objects are used for and need assistance to eat in a dignified way. The nurse told us they had not received any external advice/training regarding how to care for people with dementia and had neither requested advice themselves. We told the provider and manager we considered staff required training in dementia care.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us they felt intimidated by staff and so refrained from making complaints about their relative's care.

We observed carers speaking to in a respectful manner but we observed carers rushing and often unable to sit and talk with residents. Therefore, we were concerned staff were unable to listen and involve people in their care to establish what their wishes were. We also found the care being provided was task based such as staff rushing from one person to another to assist them with toileting.

We viewed one relatives/resident's meeting minutes and found people did not always receive a response from the comments/problems raised.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the service was not always responsive. People's complaints had been logged but they had not always been responded to appropriately. The provider had started to actively seek people's feedback about the service and act upon this.

As part of our inspection we reviewed documentation to see if reviews of the care plans and risk assessments were taking place according to the changing needs of the people who lived at the home. We also looked to see if documentation was completed and care needs were being recorded.

We viewed documentation for 10 people who had complex nursing needs. One person who we observed who required assistance with eating had been seen by a Speech and Language Therapist on 20/4/2016 with advice recommendations as follows: "Appears at risk of aspiration, recommendations, 1.Stage 1 thick fluids – small sips at a time, 2.Puree diet from teaspoon 3.Full assistance 4.Slowly 5.Upright and alert 6.Stop if condition of chest/swallow deteriorates. Despite these specific recommendations, this had not been updated in the care plan. We checked the date on the care plan and it stated 04 July 2015, there were no evaluations of care in the records for 2016 and the food monitoring chart was incomplete. We also read in the records that the person had been seen by a Dietician on 25 May 2015. The recommendations were 1.Diabetic controlled by diet, 2.Encourage little often, 3.High energy snacks and meals.4.Monitor weight & fluid intake.5.For review in 4 weeks via telephone. We checked to establish if the person's weight had been monitored as requested by the Dietician and we found a weight recording on 29 April 2015 recorded 54.6kgs BMI 23 and on 10 September 2015 weight recorded 44.1.kgs BMI16.6. There were no further weight recordings following this. Therefore, people who were at high risk of weight loss were not being monitored effectively or frequently enough to detect if they were losing weight. This placed people at risk of secondary problems as a result of weight loss such as a deterioration of the condition of their skin and tissue viability and consequently at unnecessary risk of harm or neglect.

When we revisited the care home on 02 March 2016 we noticed there was a drink of Ensure food supplement on the person's locker. We asked the carer about fluids and why she had not been given the Ensure (food supplement). The carer replied, "she is on end of life care". In her case notes it was documented she had "advanced dementia". There was no mention of end-of-life care. We were concerned regarding the staff member's attitude towards the person with advanced dementia as they were knowingly not administering a prescribed substance to provide additional nutrition for the person. Nutrition is important for people who suffer with dementia and we were concerned the care being provided was not person centred or meeting the health needs of people thereby resulting in neglect.

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

We found evidence of one resident/relative's meeting on 17 December 2015. We could see from the minutes of this meeting that six relatives were in attendance and no residents. We read in the minutes that one of the issues was the lateness of lunches for people and the knock on effect with people then not being

supported to go to the toilet until after lunch. The manager's response was that they had already provided the weekday cook with additional support by taking a member of staff off the fluids round to assist in the kitchen. The manager agreed to discuss the concerns with the kitchen staff and monitor the situation. On the second day of our inspection we observed residents in their rooms were having food at 1.45pm. This suggests that changes were not being made according to the relatives/resident's wishes. We saw other evidence of concerns being raised such as the cleanliness of people's rooms. Whilst we read the manager suggested a deep clean of rooms commenced in January 2016, we found domestic cleaning charts were not completed during our inspection and according to the room cleaning chart in one person's room which had a malodourous smell their room had not been cleaned for two days of the week of our inspection.

We found complaints had not always been investigated thoroughly and could not see contemporaneous records of what was done following the complaint. For example, we viewed a complaint raising concern a drink that had not been thickened as recommended by the Dietician and Speech and Language Therapist. The complaint also highlighted marks on the person's arms which could not be explained. The manager documented they had taken witness statements from staff but there were no copies of these statements or a response to the complainant. We viewed another complaint regarding skin tares/markings observed on a person but there was no evidence of an investigation or response to the complainant.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were informed by the manager that activities were provided for one hour each afternoon from Monday to Friday each week. Following the inspection the provider sent us photographs to demonstrate that residents had made cakes and bonnets with the activities coordinator and had participated in a music activity.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found the service was not always well-led. Systems had been introduced to check on the quality of the service and to act on any identified shortfalls. However, these needed to become embedded in practice. We found a number of breaches of the Regulations at the last inspection.

The manager had been in post for approximately eight months and had begun to attempt to make some changes within the service at the time of our inspection.

We were concerned the manager did not have basic systems in place. For example, we requested a record of hospital admissions over the past 6 months. We were informed the service did not have a system in place to record all hospital admissions and it was documented in the daily records if a person was admitted or received back in to the care home. This was discussed with the manager due to our concerns that as a service they would be unable to complete an effective audit to highlight potential patterns emerging.

We found a person's care record in the entrance of the care home which was accessible for other residents or visitors to view. This was a breach of confidentiality which had not been identified by the manager.

The manager informed us the Training and Compliance Officer had implemented training in hydration and nutrition due to previous concerns from a previous inspection were people were not having adequate amounts of fluids. Despite the service implementing additional training and requesting one staff member to focus on administration of fluids, we did not find any system in place to audit their effectiveness. Despite the inspection highlighting people were at risk of dehydration through not having adequate amounts of fluids, we found the same practice continuing when we returned to the care home at a later date. Therefore, we found the service failed to mitigate risks even when they were highlighted to them a number of occasions.

We found there were no robust systems in place for carers to communicate concerns to qualified staff regarding people's day to day needs. We were unable to view any system of documentation where staff had highlighted concerns which were then actioned by qualified staff. Staff told us they reported concerns verbally and the qualified staff documented information in the care records. However, we found daily records were often incomplete or missing. We requested daily evaluation forms for one person in order for us to track their care from October 2015 to date. We found gaps in the records and pertinent information missing related to when the person's marks/bruises first appeared. The manager was made aware that we were concerned about the robustness of their systems to document information. The service told us as part of their action plan that they would improve communication between the unqualified and qualified staff by implementing a communication book. We revisited the care home and viewed the communication book. We found the communication book had hand written entries in it which were going back to October 2015. Therefore, the suggestion of a communication book which the service made to the Commission was not something new. The Commission were led to believe implementing a communication book was a new system of ensuring the day to day needs of the residents were being communicated between the carers and nurses. On inspection we were handed a communication book which had not been used daily by staff since

October 2015. We asked staff if they were aware of a communication book and one staff member said they hadn't heard of it or where it was in the care home. Another staff member said they didn't write in a communication book and passed on any concerns verbally. The service had failed to act in a transparent manner or to implement a system of good communication between carers and qualified staff despite this being highlighted by the inspector.

The qualified staff were not always following their code of conduct. We observed a person's care file a second time when we re visited the care home on a different day. We found a qualified nurse had retrospectively written and signed care records which we saw in the care file. The Nursing and Midwifery Council states - "Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements." This was reported to the Nursing and Midwifery Council by the Commission. There were no systems in place for the manager to have an oversight of what practices the qualified staff were following.

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