Hollyberry Care Limited

Kingsley 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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on the 7 September 2016. Kingsley Nursing Home provides accommodation for up to 25 people who require nursing care. At the time of the inspection there were 21 people living at the home.

There was a registered manager in post, however, at the time of the inspection they had been suspended pending investigations by the provider and the Nursing and Midwifery Council (NMC). A registered manager is a person who has registered with the Care Quality Commission (CQC) 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's medicines were not managed appropriately. We found that the provider was unaware that one person had received too much of one medicine on two separate occasions within the previous two weeks. Staff did not always record when they had administered people's medicines.

Poor standards of care had not been identified, or recognised as safeguarding concerns and as a result safeguarding notifications had not been completed to the appropriate authorities. This included the inappropriate use of bed rails, insufficient hydration and nutritional support, inappropriate care and support for people with diabetes, insufficient support to manage people's general health and wellbeing, medicine errors, inadequate care plans and neglect by a member of staff to follow medical advice following a serious fall. As a result the Commission raised six safeguarding alerts following our visit to the home.

People were not protected from unsafe care as their risk assessments were incomplete and were not regularly reviewed or updated. The safety of the home environment was not maintained and we identified a number of areas that caused concerns regarding safe fire procedures which we referred to the local fire service and they identified a number of breaches of the fire regulations.

People did not have enough to eat and drink to maintain their body weight, health or well-being. We had serious concerns about the oversight of people's nutritional care which led to most people losing weight and becoming dehydrated. There was a lack of nursing oversight to identify when people required medical care or referral to other health professionals. We told the provider to take urgent action for five people who were particularly frail. People were not provided with adequate support to eat their meals, or drink adequate fluids.

People had not been adequately assessed regarding their mental capacity to make their decisions about the care they received. Generic mental capacity assessments had been made for everybody which were not tailored about the decisions people may be able to make for themselves, or what could be in their best interests. Generic Deprivation of Liberty Safeguard (DoLS) had been made however they did not specify that people were being cared for in a recliner chair, or that bedrails were in place which could act as a form of

restraint. We raised concerns about this and requested the home urgently review the suitability of these measures, and if appropriate to make urgent DoLS applications.

People's healthcare needs were not adequately met. It appeared that nursing staff took people's clinical observations such as blood pressure and pulse, however when results significantly changed and there were indications that people's health had deteriorated, no action was taken to highlight this to the GP. When people had seen the GP, their advice was not adequately documented and there was insufficient evidence to show staff had followed this advice. In addition, staff had inadequate systems to manage the wound's people had and the care they received.

Staff that were in senior positions did not have the knowledge, competence or ability to provide staff with adequate direction to ensure everyone's needs were met. Members of care staff did not have the appropriate skills to support people to have all of their care needs met. There was a failure by staff to recognise that people did not have their care needs met.

People choices and preferences were not always respected. People with mobility difficulties asked to go into different areas of the home and this was not accommodated by staff, and they were left where they were, against their wishes.

People's care plans showed that most people had not been involved with their care planning. Staff had a limited knowledge of people's preferences or how they liked to spend their time.

Inappropriate assessments had been made about people's needs before they moved into the home which failed to recognise that the service could not adequately meet their needs. This meant people were not always able to live at the home on a long term basis as expected.

People were not supported with their care and support needs in a consistent and person centred way. Not everyone had a care plan in place, and the care plans that were in place contained insufficient information and guidance to staff about how people liked to receive their care. Care plans were not adequately reviewed or updated when people's needs changed.

People did not receive care that met their needs for pressure relieving support. Pressure mattresses were not set to the appropriate setting for each individual and people were not regularly supported to change their positions.

People were not supported to live a fulfilled life. Staff did not engage people in meaningful conversations or activities and people spent long periods of time without any significant interaction.

Inadequate systems were in place to identify and manage complaints. People were not supported to make complaints, and there was a failure to record and investigate people's complaints.

There were inadequate arrangements for the day to day management and clinical leadership within the home. Standards of care had deteriorated and this had not been identified or actioned. Quality assurance systems were unsatisfactory and relied on members of the management team alerting the provider to changes of people's needs or of significant events.

Records that were maintained within the home were not adequately reviewed. For example, people's food and fluids charts were not reviewed, people's repositioning charts were not reviewed, accidents and incidents were not reviewed and people's care plans were not audited. This led to significant failures of care.

There have been seven breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken urgent action to place conditions on their registration that prevents any further admissions to the home and provide evidence that people are receiving safe care and treatment.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not safeguarded from harm as the provider did not have adequate systems in place to prevent, recognise and report any suspected signs of abuse.

People's medicines were not always appropriately managed.

Risks associated with people receiving safe care were not regularly reviewed or acted upon.

The home environment was not adequately maintained with appropriate fire safety precautions in place.

Is the service effective?

Inadequate

The service was not effective.

Appropriate assessments had not been made as required by the Mental Capacity Act 2005 (MCA 2005). People were at risk of being restrained as Deprivation of Liberty Safeguards (DoLS) applications were being implemented without proper assessments and best interest meetings regarding the use of recliner chairs and bed rails.

People did not receive enough to eat or drink to maintain their weight, their health or well-being and there were inadequate meal choices for people.

People's healthcare needs were not met by appropriate professional reviews and input.

Staff received regular training however it failed to provide them with the appropriate skills and knowledge to ensure people received good care.

Is the service caring?

Inadequate

The service was not caring.

People did not have their wishes and choices respected and staff

ignored people's requests.

People were not treated in a person centred way.

People were not involved in the planning of their care and support.

People's privacy and dignity was not maintained.

People were not able supported to lead a fulfilled life.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not adequately assessed prior to admission.

People did not have appropriate care plans in place that met their needs or provided suitable guidance for staff.

People did not receive care that met their needs regarding their pressure area care.

People and their relatives were not supported to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

There was a Registered Manager in post however they were under investigations by the provider and NMC at the time of our inspection.

There were insufficient quality assurance systems in place to monitor the quality of care people received.

Records relating to the management of the home were not reviewed or acted upon to prevent similar incidents reoccurring.

Staff lacked direction and appropriate guidance from management.

Kingsley 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 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 inspection was carried out by two inspectors on 7 September 2016.

Before our inspection we received concerning information about the care people received whilst at the home. We reviewed all the information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority and the clinical commissioning group who commission services from the provider.

During the inspection we spoke with six people who used the service, three relatives, five members of staff including nursing staff and kitchen staff, the deputy manager, the acting manager and the registered provider. We reviewed the care records of six people who used the service and looked at everybody's food, fluid and turn repositioning charts, and three staff files. We observed how care and support was delivered in communal areas, people's rooms and at meal times.

We also asked to look at other information related to the running of and the quality of the service. This included accident and incident documentation, quality assurance systems, maintenance records, training information for care staff, and arrangements for managing complaints.

Inadequate

Is the service safe?

Our findings

People's medicines were not always managed appropriately and they were at risk of not receiving their medicines safely as safe systems and processes were not in place to manage their medicines.

Staff did not always have all of the information they required to provide people with their medicines safely, for example there was no information documented about three people's allergies, this meant that there was a risk that people could be given medicines they were allergic to. Staff did not follow the homes medicines procedure and were not recording the times when they gave Paracetamol. Seven people had paracetamol based medicines given regularly at each medicine round, however, staff did not record the time that they gave it. There was a risk that people could receive their paracetamol too close together as paracetamol must be given more than four hours apart. We were concerned to note that one person had received Paracetamol and Co-codamol (which contains paracetamol) at the same time on two separate occasions; this meant that staff had administered too much Paracetamol. This had exposed the person to risk and it was a concern that staff had not identified this and had not sought medical attention. We raised a safeguarding alert about this.

Staff did not always record when they had administered people's medicines; we saw that there were gaps in the Medicines Administration Records (MAR) for 11 people. Not all of the medicines were in blister packs, and stock checks of boxed medicines were not carried out. This meant that the provider could not tell if people had received all of their prescribed medicines and no action had been taken to establish whether the gaps in recording was a records issue or to determine whether the people concerned had not been given their medicines. This was exposing people to the risk of instability or deterioration in their health.

This is a breach of Regulation 12 (g): Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has failed to implement robust systems and processes to identify and respond to concerns or practice which may expose people to the risk of harm. Over the last six months there has been an increase in the number of safeguarding alerts made in relation to the quality and safety of care provided to people in the home. This included alerts that had been made by other agencies such as the ambulance service and GP. The Northamptonshire County Council safeguarding team had asked the provider to ensure that some of these matters were fully investigated and action taken to prevent reoccurrence. However, at the time of our inspection we found that investigations had not taken place and action had not been taken to improve the service provided or to protect people from further harm.

Although staff had received training in safeguarding of vulnerable adults, there was no process in place to ensure that they fully understood their role and responsibilities in this regard and there had been no assessment of their competency. At the time of our inspection we found that they did not understand the procedures that were in place and were unaware of how to recognise signs of abuse or neglect or how to raise a safeguarding notification to the local authority.

Our inspection findings identified a number of issues and concerns about care practice within the home and exposed areas where people were being cared for in an inappropriate or unsafe way; yet the staff team and the provider had failed to identify or address these matters. These included the inappropriate use of bed rails and furniture to restrain people, insufficient nutritional and hydration support for people, inappropriate care and support for people with diabetes, insufficient support to manage people's healthcare needs, medicine errors and inadequate care plans. Nursing staff had not provided sufficient care following an accident or injury and there had been neglect by a member of staff to follow medical advice following a serious fall.

These were all exposing people to the risk of harm, had not been recognised as such and no action had been taken to address the underlying failings in this regard. These matters had not been raised with external agencies and as a result people continued to not receive the care they required to meet their needs. We consider that this was exposing people to the risk of harm and raised safeguarding alerts regarding all of these areas.

This was a breach of Regulation 13 (2 & 3): Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has failed to implement effective risk management strategies. People were not being protected from risks as there were no accurate or current risk assessments in place. At the time of our inspection we found that three people had acquired pressure ulcers and due to their frailty most people were at risk of pressure ulcers. There had been no regular assessments of people's skin integrity. The assessment tools designed to assess people's risk of pressure ulcers such as the Waterlow scale had not been calculated accurately and gave a false picture of people's risks. Where people were at risk of acquiring pressure ulcers, there were no clear instructions for staff to provide pressure area care at specific intervals, or instructions for the air mattress settings. We found that mattresses had been set to the wrong setting for people's weight and people did not have their pressure areas relieved at regular intervals. The lack of accurate risk assessment and plans to mitigate the risks put people at risk of acquiring pressure ulcers and we found evidence that people had acquired pressure ulcers as a result.

Two people had bed rails fitted to their beds; records showed that staff had identified them as at risk of harm as they could climb over the bed rails. It was a serious concern that the bed rails had been fitted without a full assessment of the need for these and without sufficient attention to how the risk of using this equipment could be managed for these individuals. It is CQCs view that the fitting of bed rails for these people could put them at even greater risk of harm.

People's falls risk assessments were inadequate and people were experiencing injuries as a result of falls. Where records showed that people had a fall, the risk assessment had not been updated to reflect the increased risk. There was evidence that people were having multiple falls, and there was no change in their care to prevent further falls. We saw that there were records of people having multiple falls resulting in injuries and met people who had bruising and a broken arm, which staff told us was as a result of falls.

This was a breach of Regulation 12 (2) (a): Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to implement systems and processes to ensure that the safety of the premises was continually considered and action taken to rectify any areas of concern. We found that previously identified risks within the home environment had not been resolved. For example, on the day of our inspection we found that the door to the cellar was unlocked despite a recent incident in which one person had fallen

down the concrete stairs to the cellar. This continued to pose a risk to people in the home and particularly those living with dementia, who were at risk of falling down the cellar stairs. It is a serious concern that it took CQC intervention before the provider took action to ensure the door remained locked. The provider stated that this had not been prioritised prior to the inspection as they were unaware of the incident until they were informed by the CQC during this inspection.

We observed that people were not protected from the risks associated with accessing the homes main kitchen as the kitchen door was always open and easily accessible from the communal corridor. We were told that this was normal practice and were concerned that we had to intervene before the risks involved in this practice were recognised or addressed.

People were at risk due to inadequate fire safety measures in place. There was no suitable signage displayed in communal areas to indicate how to exit the home in the case of fire. The front door was kept locked for the safety of people who had been identified as at risk if they left the home unaccompanied; however in an emergency the door could not be opened without a key, which was not carried by all staff. We referred these concerns to the community Fire Officer who found the home to be in breach of fire regulations and required the provider to take action to ensure these matters were resolved.

This was a breach of Regulation 12 (2) (d): Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to implement a systematic process to ensure that staffing levels and deployment of staff was based on an up to date assessment of the dependency of people living in the home. At the time of our inspection we found that there was no accurate system in place to identify people's changing needs or fluctuating dependency and to relate this to staffing arrangements.

Staff did not have the experience or knowledge of people living in the home. We observed that many people were in bed. The deputy manager told us that most of the staff on the shift on the day of inspection were new, and did not know the people living in the home; they told us "They [staff] are not aware of who needs to get out of bed, they are still learning."

There was no close supervision or oversight of the team leader who allocated staff to areas of the home to provide care. We observed that two people did not receive their meals at lunch time and staff were prompted by the inspector that they had not received their meals. Most people in bed relied on staff to pre-empt their needs as they were unable to use the call bell to summon assistance. People had to wait for their care needs to be met; we heard people call out for assistance or ask to go to bed, but staff were not located near enough to hear them or said they were busy and would be back. We observed that there were not enough staff to attend to all the people in their rooms sufficiently to provide personal care, pressure area care and drinks.

The acting manager was an experienced nurse who usually worked night shifts in the home and had stepped into the role of acting manager when the registered manager was suspended. The acting manager had no previous experience in running a nursing home or current experience of the systems and processes in place on the day shifts and relied on the provider to guide them in their new role. The appointed deputy manager did not have any managerial experience and was relatively newly qualified and lacked the skills and experience to oversee the wound management, clinical observations and assessment of people's needs.

The provider was in the process of recruiting registered nurses and was waiting for the relevant checks to go

through before they could start their employment. In the meantime they were using agency nurses, particularly at night. This meant that the nursing management of all the people in the home relied on the newly appointed acting manager, an inexperienced nurse and agency nurses. There is a risk that people's needs would not be met.

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

People were protected against the risks associated with the appointment of new staff because the required checks were completed before staff started providing care to people. There were appropriate recruitment practices in place. Staff employment histories were checked and staff backgrounds were checked with the Disclosure and Barring Service (DBS) for criminal convictions before they were able to start working with people who used the service.

Inadequate

Is the service effective?

Our findings

During our previous inspection in March 2016 we found that 12 people had been placed at risk of being unlawfully deprived of their liberty. We asked the provider to provide evidence that they had assessed people for their mental capacity and make applications to the local authority for those persons requiring authorisation of Deprivation of Liberty Safeguard.

The Mental Capacity Act (MCA) 2005 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).

During this inspection we found that the provider had not ensured that the DoLS applications made related to the actual restraints that were in place. The staff had applied for generic DoLS applications for everybody at the home, and not just for those people who did not have the mental capacity to make their own decisions. The DoLS applications that had been submitted contained all of the same information and had not been made on an individualised basis which highlighted specific decisions that people were unable to make for themselves. The applications were generic about the restrictions of being cared for in a nursing home and made no reference to the use of bed rails, recliner chairs or a locked front door. For example there had not been a mental capacity assessment or a best interest meeting held to establish whether one person required the use of a recliner chair tipped back to restrict their movement to safeguard them. We requested the home urgently review the suitability of these measures, and if appropriate to make urgent DoLS applications. Many other people had bed rails in place and there had not been adequate assessments to consider if this was an appropriate and necessary way of keeping people safe. There had been no DoLS applications for people who had bed rails in place. In addition the front door was locked at all times and people were not able to leave the home if they wished, and there was no reference to this in the DoLS applications that had been made.

This is a continued breach of Regulation 13 (5) (7) (b): Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to implement effective systems and processes that would protect people from the risk of malnutrition and dehydration. At the time of our inspection we observed that people looked very thin and frail. Records showed that 11 people had lost weight in the month of August 2016. One person had lost 13% of their body weight, another person had lost 8% and five more people had lost over 4% of their body weight in one month. Nine people had not been weighed since 1 August 2016 and we noted that three of these people had lost weight in July 2016.

It is a serious concern that the significance of this weight loss had not been recognised or responded to. We

found that none of the people who had lost weight had been referred to the GP or dietitian for review or dietary advice. We were so worried about five people that we instructed the provider to make immediate referrals to the GP, dietitian and Speech and Language team (SALT) for assessment and review. We raised safeguarding alerts regarding people's weight loss. It is a serious matter that CQC had to intervene and direct this level of care; however we were not confident that this would happen without our directions.

Nursing staff had not accurately assessed people's risks of not eating and drinking. Although the registered manager had used a recognised Malnutrition Universal Screening Tool (MUST), the information was inaccurate. Staff had not referred people to their GP and dietitian when they had been assessed as being at risk. People were at risk of not being identified as being at risk of not eating or drinking enough to maintain their health and wellbeing.

Many people needed support and assistance to eat and drink. We observed that where people were in bed, staff did not move them into a suitable position to eat their meals; instead we saw that people were left on their side whilst being helped to eat. One person's relative told us they came in every day and supported their relative to eat. They said, "[Name] has pureed food, they [the staff] tell me she has gone off her food, but I can get her to eat; she always likes the puddings." Staff had recorded on this person's food charts that they did not regularly have their breakfast or evening meal as they were recorded as asleep or refused; and staff we spoke with were not aware that they preferred sweet foods which had not been offered. It was concerning that this person had lost a significant amount of weight and was not receiving the appropriate support from staff to maintain their weight.

There was no adequate system in place to ensure that people received sufficient food to maintain their health and wellbeing. We observed two meal times, and saw that where people were asleep they were not woken to receive food and where people refused food, they were not offered an alternative. Staff recorded on food charts what people ate, records showed that two people regularly did not receive breakfast as staff had recorded they were 'asleep'. There was no evidence that these people were offered a breakfast when they awoke.

Where people had refused their meal, records showed and we observed that no other food was offered until the next meal time. The food charts had areas to record snacks however there were very few snacks recorded on any person's food chart for the two weeks prior to our inspection. We observed one person starting their meal; however, when the telephone rang, they were distracted and walked away from their meal; staff did not notice that they had stopped eating and there was no provision to ensure that the person ate their meal.

People were at risk of receiving food that was not suitable for their needs. One person's relative said, "On Fridays they give her fish and chips, she can't eat the batter as it's not pureed, I have to scoop the fish out and give it to her." We observed that the kitchen staff had a list of people who required a pureed diet; however, the list was not complete as staff told us that others not on the list also required pureed food. There was no information available to care or kitchen staff to indicate who required fortified food or a sugar free or diabetic diet. We found there were six people who had diabetes that required a sugar free diet, that were at risk of not receiving their required diet. One person had a food allergy which was not indicated in the records provided to kitchen staff, and although the kitchen staff were aware, there was a risk that care staff who prepared the evening meal were not aware. This meant that there was a risk that they would receive this food and have an allergic reaction.

People were given no choice about the food they were offered and if they did not like what had been made for them; there were no other meal options. One person told us, "If I don't eat what they give me I don't get

anything else. There are snacks sometimes but no other meals." The kitchen staff showed us the meal prepared and said that there was no alternative planned as they had not been asked to provide this.

People were at risk of choking as there was no clear indication of who required thickened fluids. New care staff were not provided with information about people's requirements. Although the Medicine Administration Records (MAR) showed that two people required thickened fluids with their medicines there was no indication in the kitchen or in people's care files that they required thickened fluids. We observed that one person did receive thickened fluids however we could not be certain that everyone who required thickened fluids were receiving them as there were insufficient systems and guidance for staff to show this.

People were not receiving enough to drink to maintain their health and wellbeing. We observed that people were not offered a drink if they were asleep. Staff had recorded that people were asleep during the day for long periods. Where people were awake, we observed that staff spent little time with them to encourage them to finish their drink. Records showed that two people did not receive drinks in the mornings over the last two weeks; staff had recorded they were 'asleep' and records showed they did not receive any drinks until lunchtime. These two people's fluid charts showed that staff recorded they had drunk between 250mls to 660mls a day. We observed that both people were in bed in their rooms and staff did not go into their rooms regularly, or spend very much time in the room when they did. We were concerned that people had not received fluids to combat the effects of the hot weather over the last few weeks. Prior to our inspection we received information of concern from relatives that people were calling out for drinks and appeared thirsty. We found that people were sleepy, which can be a sign of being dehydrated from not receiving enough fluids. However, the more people slept the less fluid they received.

People were at risk of not being identified as being dehydrated. Although staff recorded when people had their incontinence pads changed, there was no oversight of these records to identify when pads had not been changed or people's pads were dry. This could indicate that people were dehydrated; they had not been referred to the GP for review. There was no monitoring of whether people were dehydrated or if they required a GP review. We were so concerned that people were not receiving enough to drink to maintain their hydration, health and well-being that we raised a safeguarding alert and prompted the provider to provide drinks.

This is a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. agreed

People's healthcare needs were not met by nursing staff. Although staff took people's clinical observations such as blood pressure and pulse on a monthly basis, we saw that where people's observations showed a change from their usual readings, nursing staff had not identified this or referred people to the GP for review. Three people had a significant change in their blood pressure readings in the last month which indicated that their health had deteriorated. We asked the provider to make immediate referral to the GP for review and raised safeguarding alerts to the local authority.

People were at risk of poor wound management as staff were not able to tell us who had wounds or what the management plan was. Nursing staff recorded the on-going care they provided in a wound management folder. Records indicated that eight people were receiving care for a total of 20 wounds. These records showed that the wounds were for injuries received, diabetic ulcers and pressure ulcers. The accident and incident records indicated that one person was receiving treatment for an injury to their ear which was not included in the wound management folder. The on-going care provided for these wounds had not been updated since 25 August 2016. The nurse told us they had redressed the wounds since 25 August but they could not tell us which wounds were being treated or their progress in healing the wounds. There was a risk

that people had not had their wound care as there were no records and staff were not aware of all the wounds.

This is a particular concern given that one person was admitted to hospital in August 2016 with sepsis and whose wound dressings and bandages were recorded as being black at the point of admission. Another person moved to a different nursing home where nurses identified concerns with the person's wounds management, and the person confirmed that their dressing had not been changed for over a week. Safeguarding alerts were raised by other health professionals and the CQC in relation to these and there are on-going investigations into these cases.

Where staff recorded that people had been seen by the GP, there was no record of why they had been seen or what the GP's instructions were. We saw that people had lost weight and had not been referred to the GP or dietitian and people had wounds that had not been reviewed. Where there was evidence that the GP had visited, there was no evidence that they had been reviewed for wound management or poor food intake. There was a risk that the GP had not been advised of all the relevant information about people's conditions and the care they had received, for them to provide an informed decision about whether any further assessment or treatment was required. There was also a risk that GP instructions would not be followed as there was no record of the visit and the advice they had provided.

This is a breach of Regulation 12 (1) (2a and b): Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have the competencies and skills to provide people with care that met their needs. Although staff had received training in subjects such as safeguarding vulnerable adults, manual handling and nutrition their competencies in these subjects had not been suitably tested as we found there were elements of care that were not adequate.

Staff that were in senior positions did not have the knowledge, competence or ability to provide staff with adequate direction to ensure everyone's needs were met. We observed that the team leader did not realise that two people had not received their meals, or that staff were not responding to people's requests. We observed that there was a lack of daily supervision or oversight of staff which meant that there was no recognition that staff were not providing adequate food and drinks or pressure area care. Staff failed to recognise when to report to senior staff that people had not had an adequate amount to drink.

Staff did not receive adequate supervision in order to provide safe care. Senior staff failed to recognise when staff were not performing their duties well and therefore staff did not receive the supervision and guidance that was required. Some staff had supervision meetings with the registered manager and we noted that one member of staff had requested more training in dementia care; however, this had not been provided. We found that management had not ensured that staff used the knowledge acquired in their training to provide safe care.

This is a breach of Regulation 12 (2c): Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People did not always have a good relationship with all staff. One person said, "I wouldn't describe the staff as kind, but they are fair and treat us well." We observed staff talking to people when they needed to, but there was very little meaningful or person centred conversations, most conversations related to the care people were receiving. We observed a member of staff sitting next to a person, but they did not acknowledge them or engage in conversation despite the fact that they could communicate clearly. When we spoke with the person they told us "I am uncomfortable, my back hurts." Staff had not realised the person was in pain as they had not taken the time to talk with them.

People were not supported to live a fulfilled life. One person explained that it could be quite isolating living within the home. They said, "There's not much going on here and the staff very rarely come and talk to me." People's care plans contained some information about people's life histories and interests. However this was not utilised by staff. During our inspection we did not observe staff attempt to engage people in any form of activity or meaningful conversation. People's preferences of where to spend their time were not always respected. There had not been arrangements to ensure that people could go outside if they wanted to.

People expressed their views, and requested staff to move them, but their requests were not listened to. We heard three different people who were in communal areas of the home asking staff to go to their bedrooms. We also heard one person who was in their bed ask staff if they could get out of bed. The staff ignored these requests and did not support people with these decisions and all four people were left where they were. People repeated their requests a number of times throughout the inspection and there was insufficient information within people's care plans to reflect that staff were acting in people's best interests.

People did not get an option of staying in bed or getting out of bed. There was no evidence that people were given a choice of where they spent their time, or that it was in accordance with people's wishes.

One person told us that they felt happy telling the staff if they were unhappy or wanted to complain about something, however, we observed that this person continually asked to go to bed after lunch and their requests were ignored. We heard them tell staff that they were unhappy that their requests had been ignored; staff continued to ignore the request and offered no support to make a complaint.

Not all the staff knew the people who lived in the home as they were new or agency staff. One relative told us prior to the inspection that when they visited, the nurse took them to the wrong person. They explained that the nurse could not identify their relative and the family were left to find their relative within the home. This was a concern as people were at risk of not receiving their care or medicines due to staff not knowing the people in the home.

People were not involved in the planning of their care and support. The care plans that were in place did not reflect people's preferences or show that people had been asked about how they would like their care. We found that one person's care plan recorded they had been involved in answering one of the questionnaires

about their mental health, however the answers recorded raised concerns that the person had not provided these responses, but that staff had recorded the responses in their absence.

People did not always receive their preferred food or drink. One relative contacted us to explain that they had supplied coffee-mate for their relative to have in their coffee as the home did not stock this. The coffee mate had been recorded as having been given. However, the jar of coffee mate remained sealed and unused. There was no choice of meals and people were not offered alternatives if they did not like what they were given.

People could not always express their views as not all staff understood them. Some staff did not have English as a first language which led to some staff being unable to communicate effectively. For example staff could not pronounce people's names, and strong accents led to misunderstandings. We observed one care staff providing a drink; they could not make themselves understood as they repeatedly said "Joyce Joyce" instead of juice. This misunderstanding meant that the person did not understand what was being said and missed the opportunity to have a drink.

This was a breach of Regulation 9 (1) (a) (b) and (3): Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to spend time with their visitors and relatives when they wished. One visitor told us they come most afternoons but if they wanted to visit at another time they could do so. Another relative visited daily, they told us they were made to feel welcome. However, other relatives told us prior to the inspection that they found the registered manager to be unapproachable and did not feel they could bring up any concerns without prejudicing their relative's care.

Inadequate

Is the service responsive?

Our findings

People were admitted to the home with specialist needs such as mental health needs even though the home did not have the staff with the skills and knowledge to manage their complex behaviours and could not provide for their needs. People had been assessed prior to moving into the home since June 2016 and admitted on the understanding that it would be their permanent home. However, staff did not have the appropriate skills and knowledge to support people with complex behavioural problems properly. As a result, not everybody that had been assessed as suitable to live at the home were able to remain there on a long term basis. This was disruptive to people who had moved to the home in the belief this would be their permanent home. During our inspection the provider confirmed that two people had been asked to move out of the home as they were not able to meet their needs.

People were not supported with their care and support needs in a safe and consistent way. At least one person who had been in the home for a month did not have a care plan in place, despite having high care needs. Care staff did not have clear guidance from senior staff and the information on how to provide care that met people's needs was not available in the care plans. Care plans that were in place were incomplete, had not been reviewed on a regular basis or after people's health and wellbeing had changed. For example, after one person had broken their arm, the person's care plan had not been reviewed or updated to reflect any additional support the person may require. We observed that people who were at risk of acquiring pressure ulcers laying in the same position for long periods of time, there was no instruction for staff on how often they should help people move to relieve their pressure areas.

Staff did not have clear guidance from senior or nursing staff on how to recognise triggers for people's challenging behaviours or how to respond to them. People's care plans did not describe what triggered people's behaviours or how to respond to people when they presented with anxiety. We observed that staff did not always provide the reassurance and communication that people required to prevent or reduce distress. For example we observed one person repeatedly shouting out and showing signs of anxiety. Staff were inconsistent in their approach and for the majority of the time the person was ignored, we saw that the person became more vocal and distressed when they were ignored. This person's care plan did not provide instruction for staff to help reduce the person's distress.

People who were in bed had no reliable means of calling for assistance as they did not have call bells, or were unable to use call bells. Staff did not routinely check on every person and one person was left without a drink, food or position change between 9:30 am and 1pm. We heard one person calling out for support a number of times and staff did not respond as they could not hear the person. We asked staff to go and visit the person and they reacted quickly but adequate systems were not in place to ensure people had the support they required

Not all staff were aware of who had diabetes and there were no specific plans to manage their diet. This meant that people who required a sugar free diet were at risk of receiving meals with sugar in them, which could raise their blood sugar levels to an unhealthy range. People living with diabetes did not receive the close monitoring of their blood sugar levels they required to maintain their health. One person had not had

their blood sugar levels recorded for three weeks; the staff planned to take the blood recordings weekly, however, as the person had refused on two occasions, the staff did not attempt to obtain the blood sugar levels when the person was more compliant with treatment. There was a risk that this person's blood sugar levels could be out of normal range and require medical treatment, and as the levels had not been monitored nursing staff would not be aware. We brought this to the attention of the provider who arranged for the regular blood sugar monitoring to be reinstated. The acting manager told us and we saw in the records that we reviewed, that assessment and care plans for people with diabetes did not provide suitable guidance for staff on what to do if blood sugar levels varied. There was a risk that staff would not have sufficient instruction from the care plans to treat a person whose blood sugar levels were not within their normal range. The care plans had not been regularly reviewed and did not contain sufficient detail to ensure that people consistently received the care and support they required.

People did not receive care that met their needs. We saw that people who required an air mattress to help relieve their pressure areas did not have these air mattresses set to a therapeutic setting. One person who had a pressure ulcer was lying on an air mattress that was set to 'static', it was very hard and was not providing any pressure area relief. Another person had their mattress set to the wrong setting for their weight. We showed the deputy manager that the setting on the mattress was set to static and the alarm had been switched off. They appeared unfamiliar with the mattress settings and did not know what to do to rectify them. People did not have updated accurate risk assessments or care plans that reflected their current needs and we saw that people had acquired pressure ulcers.

People who required regular position changes to help relieve their pressure areas to prevent pressure ulcers were not supported with this. We observed that people were left in the same position for many hours, however, staff had recorded that people had been moved. For example one person remained on their left side, partially sitting up during the whole of our inspection; we also observed that staff provided their lunch whilst in this position and had not changed their position to be a more suitable position for eating. We looked at the care records for people who were unable to communicate with us and saw that there were inconsistent timings of people's turns. For example we observed two people where the care records stated that they had received personal care and position changes for times in the future; they remained in their respective conditions for many hours. People's records did not match with people's current positions so it was unclear if staff had inaccurately completed people's records, or if people had been left in the same position for lengthy periods of time. For example, where the care records stated someone was on their right side, we found them in a different position, we asked staff if the person was able to move by themselves; they told us that they could not, and relied on staff to help them to move. This is of concern as people who are not helped to relieve their pressure areas regularly are likely to get pressure ulcers.

People who required regular personal care to maintain their skin integrity did not receive this. We observed people being left for long periods without care, and records showed that some people had their incontinence pads changed only twice a day, which gave concerns that people were insufficiently nourished and hydrated, or that people could be left in soiled pads. This is of concern as people can get sore and broken skin from soiled pads being left next to the skin for long periods and this is inconsistent with dignified and respectful care.

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

Relatives told us prior to the inspection that the Registered Manager was not approachable, and that they did not feel able to raise their concerns. One relative had been so worried about making a complaint for fear of reprisals that they approached other agencies including CQC; they told us "I don't feel able to complain

directly to the home whilst [name] is there." We raised a safeguarding alert relating to the complaint as the person was not receiving care for their wounds. The person's health deteriorated as a result of the poor wound care and was admitted to hospital with serious medical conditions and requiring urgent treatment.

Prior to our inspection we received complaints from relatives about poor care at the home, the information they gave us provided evidence that required safeguarding alerts to be raised, these are currently being investigated by the local authority safeguarding team. The relatives had complained to the registered manager but had not been able to resolve their complaints. There were no records of these complaints in the home. The provider had not been made aware by the registered manager of the complaints that had been raised. One relative had told us prior to the inspection "I tried to make a complaint to the senior nurse but they did not take the complaint seriously."

There had been other complaints reported to the registered manager which had not been acted upon. Another relative told us prior to the inspection that their relative was repeatedly dressed in other people's clothes; they told us "I went to complain again and was told they did not have time to deal me." This is currently being investigated by the local authority safeguarding team.

It was a concern that the provider told us they had not received any complaints in the previous 12 months and had no insight of any of the complaints that had been raised.

This was a breach of Regulation 16 (1) and (2) Receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

During our previous inspection in March 2016 we found that the provider had failed to notify the CQC about two people who had the DoLS applications authorised by the local authority. Following the inspection in March 2016 the provider submitted the appropriate notification to the Commission. We were informed by the provider that no further DoLS applications had been authorised since the last inspection.

At the time of this inspection there was a Registered Manager in post, however they had been suspended by the provider pending an investigation into allegations about misconduct. In the absence of the registered manager the provider had failed to ensure that there were adequate arrangements for the day to day management and clinical leadership of the home at all times. Standards of care were poor and we continued to receive information highlighting ongoing concerns about the safety and quality of care and support offered to people. These related to the adequacy of the staffing arrangements in place and the impact these have made on the overall quality and safety of care; specifically related to supporting people with their nutritional needs, mobility needs, mental health needs and challenging behaviour.

The provider had inadequate quality assurance systems in place to audit or monitor the quality of care that people received. There had been significant trust in the management team to provide good care to people and there were no systems in place to ensure this was provided or to monitor people's experiences of care. The provider did not have any oversight of people's risk assessments, care plans or people's records and therefore had not identified the failings in these areas and had not taken any action to mitigate risk to people.

The provider relied on the management team to keep them informed about significant events; however had no systems in place to monitor or oversee these. There were no systems in place to monitor trends or patterns, for example with regards to people who fell in the home, or of behaviour that people displayed which may harm themselves or others. Accidents and incidents were not reviewed to identify if any learning or prevention could be identified. It is of significant concern that the provider was unaware of a serious incident where a person was injured following a serious fall. As a result, timely action to rectify the safety concern was not completed until CQC intervened and directed that action be taken. The systems and processes in place relating to governance and quality assurance of the care provided were ineffective. People continued to be exposed to ongoing risk of harm, neglect and omissions in their care.

All people had food and fluid charts that had been completed by staff. The records for the last two weeks were set aside in one area; they had not been reviewed. The records clearly demonstrated that people refused meals, were not given a drink or a meal because they were asleep or had eaten or drunk very little. There had not been any oversight of these records to alert staff that people were consistently not receiving enough to eat and drink or so that appropriate medical attention could be sought.

We observed that staff recorded that people were helped to move their position in bed onto their left or right side or on their back. However, these records did not relate to the actual care people received as we saw that people were in a different position to what was recorded. There was a risk that people were not being

helped to move their position to relieve their pressure areas as records showed they had already been moved.

Relatives had expressed concerns about the registered manager to CQC, and the commissioners. Relatives told us they did not feel able to complain; one relative had reported to us that they felt bullied and intimidated by the registered manager. It is of concern that people did not feel able to approach the manager with their complaints as this did not give opportunity to improve care and avoid the incidents which have arisen resulting in numerous safeguarding alerts.

Although care staff appeared friendly, staff lacked direction and appropriate guidance from management to ensure that all people living at the home received the care and support they required at the times they required it. For example, there was no structured approach to mealtimes to ensure that everybody had their meal, and that it was appropriate for their needs. Staff were not organised to ensure that people received person centred care and their needs and wishes were respected.

The registered manager had kept all of the oversight of people's care to themselves which had bred a culture within the organisation where staff had become task orientated. This had meant that staff could not see why they were carrying out specific care and did not notice that the lack of regular turns, food and drink had led to people acquiring pressure ulcers and incurring injuries from frequent falls.

The registered manager did not always notify the commission when there had been a fall, injury or allegation of abuse.

This is a breach of Regulation 17 (2a to f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered manager and provider failed to involve people in their care planning or provide care that reflected their preferences or met their needs. 9 (1a and b) (3)

The enforcement action we took:

Urgent imposition of conditions to prevent new admissions and close quality monitoring of all aspects of care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager and provider failed to: 1. provide care in a safe way. 12 (1) 2. monitor people's healthcare conditions and refer them to health professionals in a timely way. 12 (2a and b) 3. assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate any such risks. 12 (2a and b) 4. ensure that staff had the competencies and skills to provide people with care that met their needs. 12 (2c) 5. ensure that the premises used were safe. 12 (2d)

The enforcement action we took:

Urgent imposition of conditions to prevent new admissions and close quality monitoring of all aspects of care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager and provider failed to 1. report safeguarding concerns or have effective

	systems to investigate allegations. 13 (2 & 3) 2. submit Deprivation of Liberty Safeguards (DoLS) authorisation applications that were relevant to the restrictions being made to people's mobility. This is a continued breach of Regulation 13 (5) (7b)

The enforcement action we took:

Urgent imposition of conditions to prevent new admissions and close quality monitoring of all aspects of care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The registered manager and provider failed to ensure that people had adequate nutrition and hydration to maintain their health and well-being. 14 (1)

The enforcement action we took:

Urgent imposition of conditions to prevent new admissions and close quality monitoring of all aspects of care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The registered manager and provider failed to: 1. investigate or take necessary action in response to complaints. 16 (1) 2. have an effective system to receive, record, investigate or respond to complaints. 16 (2)

The enforcement action we took:

Urgent imposition of conditions to prevent new admissions and close quality monitoring of all aspects of care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered manager and provider failed to: 1. Assess, monitor and improve the quality and safety of people. 17 (2a) 2. Assess monitor and mitigate risks relating to health, safety and welfare of people. 17 (2b) 3. Maintain accurate, complete records of the care and treatment people received. 17 (2c) 4. Evaluate and improve care for people where failings had been identified. 17 (2f)

The enforcement action we took:

Urgent imposition of conditions to prevent new admissions and close quality monitoring of all aspects of care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager and provider failed to adequately deploy staff to meet people's needs. 18(1)

The enforcement action we took:

Urgent imposition of conditions to prevent new admissions and close quality monitoring of all aspects of care