Orchard Care Homes.com (3) Limited

Cleveland Park

Inspection report

Cleveland Park
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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

Overall summary

We visited the home on the 2, 9, 15, 16 and 22 October 2015. All visits were unannounced except the visit on 16 October 2015.

The home was last inspected in August 2015. We found that there was a continuing breach of the regulation relating to the management of medicines. We issued a warning notice and told the provider they needed to take action to improve.

Cleveland Park provides accommodation and personal care for up to 66 older people, some of whom have dementia. There were 52 people living at the home, two of whom were in hospital on the first day of our inspection. There were 47 people living at the home with five individuals in hospital on the last day of our inspection.

The home was divided into four units. There were two units on the ground floor providing mixed accommodation for males and females. There were two specific male and female units on the first floor.

Summary of findings

Prior to our inspection, we received information of concern about the care and treatment of people. This related to specific safeguarding concerns, moving and handling procedures and pressure area care. We took this information into account when planning our inspection.

At this inspection we found major shortfalls in all areas of the service and identified that people were at extreme risk of harm. The local authority had placed the home into 'organisational safeguarding.' This meant that the local authority was monitoring the whole home since there were concerns that some of the practices within the service were putting vulnerable people at risk. The local authority and the local Clinical Commissioning Group were closely monitoring the home and visiting regularly. They also organised for nursing staff from the local NHS Trust to visit the home to provide staff with advice and support. In addition, senior managers at the home were liaising with health and social care professionals such as tissue viability and palliative care nurses.

At the end of our first visit on 2 October 2015, the provider informed us that they would not accept any further admissions into the home as a result of our initial assessment of serious shortfalls in care delivery. This was followed up with a written agreement from the provider which they adhered to throughout.

A manager was present on the first day of our inspection. He had been in post since May 2014 but was not formally registered with the Care Quality Commission. 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 and associated Regulations about how the service is run. This issue is being followed up and we will report on any action once it is complete. The provider suspended the manager on 2 October 2015 and they resigned on 7 October 2015.

A peripatetic manager [relief manager] was managing the home on the remaining days of our inspection. They were supported by two 'project managers' who were overseeing the management of the home and a compliance officer.

Safe recruitment procedures were not always followed. There were no references in one of the staff files we examined. In addition, there were concerns that a member of staff had been working as a nurse without being registered with the Nursing and Midwifery Council [NMC]. The NMC registers all nurses and midwives to make sure they are properly qualified and competent to work in the UK. The provider has referred this issue to the police who are investigating this concern.

Day and night staff expressed concerns about staffing levels. Overall, we found there were limited interactions between staff and people throughout the day. Staff informed us that this was due to staffing levels. One member of staff on night duty raised concerns that there was often only one nurse on duty overnight to oversee the care of people who had nursing needs. During our inspection, staffing levels were increased.

We saw that the provider did not have adequate systems in place to protect people from abuse caused by acts of omission and neglect. We had not been notified of any safeguarding concerns in 2015. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns. We wrote to the provider using our regulatory powers to request further information about this issue. Following our letter, the provider submitted five notifications relating to alleged abuse which had occurred since January 2015.

Some of the décor and furnishings were worn and in need of updating. There was a strong odour of stale urine and faeces in the male unit and other areas of the home. We visited one person who was lying in bed. There were faeces on the floor and their bedding. We went back later and the carpet and their bedding had still not been cleaned.

A system to ensure the adequate stock of medicines was not fully in place. Medicines were out of stock on occasions including those for epilepsy and pain relief. The provider informed us that there had been issues with the ordering and supply of certain medicines by some GP practices and the pharmacy. The provider informed us that staff had contacted the GP practices and pharmacy to chase up any outstanding prescriptions. We noted however, that this action was not always recorded. Certain wound care and continence equipment

Summary of findings

was also out of stock. This meant people were not receiving their medicines and prescribed equipment as they should have, to ensure their needs were met to prevent any deterioration in their condition.

Staff told us that training was provided but explained that most of the training was e-learning. We had concerns with certain staff practices in relation to pressure area care, continence care, nutrition and hydration and privacy and dignity. The peripatetic manager informed us and staff confirmed that individual staff supervision sessions had not been carried out. In addition, there was no evidence that nursing staff had undertaken clinical supervision to ensure that they retained their skills and competence to practise as nurses.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. Care plans did not evidence that a DoLS assessment had been undertaken to ascertain whether the plan would amount to a deprivation of the person's liberty. We also found there was a lack of documented evidence to demonstrate that care and treatment was sought in line with the Mental Capacity Act 2005. This meant that people's rights to make particular decisions had not been protected, as unnecessary restrictions may have been placed on them.

We observed that care was not always provided with patience and kindness and staff did not always promote people's privacy and dignity. We observed staff transferring one person from their armchair to their wheelchair. Their underwear was exposed and staff did not place a blanket over them to promote their dignity.

An activities coordinator was employed to help meet the social needs of people who lived at the home. However, we saw very few planned activities being carried out. Staff explained that, due to staffing levels, they had limited time to spend with people on a one to one basis.

There was no evidence that any audits of the services being provided had been carried out. The peripatetic manager stated that none had been completed. Following our inspection, the provider contacted us and said that these had been completed and were held at head office.

There was no evidence of any surveys and the peripatetic manager told us that these had not been undertaken to obtain the feedback of people who lived at the home or their representatives. The peripatetic manager was unsure whether any complaints or minor concerns had been received since none had been documented. This meant there was no evidence to document what action had been taken in response to any complaints, concerns or feedback to improve the service.

We discovered serious shortfalls in the maintenance of records. We were unable to locate certain documents relating to people's care and treatment and the management of the service.

Due to the serious shortfalls in all aspects of the service, we wrote to the provider to request an urgent action plan which stated what actions they were going to take to improve. We visited the service again after receipt of their action plan on 22 October 2015. We found that sufficient improvements had not been made to ensure the health, safety and wellbeing of people who lived at the home.

The care was so poor that we judged the home as failing to meet every aspect of the CQC assessment framework.

Following the inspection, we took enforcement action and cancelled the regulated activities of, 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

During the process of completing the enforcement action, all of the people who used the service moved out and there was no one living at the service from 29 October 2015. The operating company managing the provider's regulated activities told us that a new operating company would take over running of the provider's regulated activities in January 2016.

Regulated activities are prescribed activities relating to care and treatment that require registration with CQC. They are set out in legislation and reflect the services provided.

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, it will be

Summary of findings

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.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found two breaches of the Care Quality Commission Registration Regulations 2009. These related to the notification of deaths of people who used the service and other incidents. This is being followed up and we will report on any action once it is complete.

You can see what action we took at the back of this report.

Summary of findings

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.

There were insufficient suitably qualified and experienced staff employed and deployed to meet people's needs and ensure that environmental standards were maintained. Recruitment procedures were ineffective and not adhered to, placing vulnerable people at risk. We had not been notified of any safeguarding incidents in 2015. Staff informed us that there had been physical altercations between people. It was unclear therefore whether the correct procedures had been followed to ensure the safety of vulnerable people.

A system to ensure the adequate stock of medicines was not fully in place. Medicines were out of stock on occasions including those for epilepsy and pain relief. The provider informed us that there had been issues with the ordering and supply of certain medicines by some GP practices and the pharmacy. The provider informed us that staff had contacted the GP practices and pharmacy to chase up any outstanding prescriptions. We noted however, that this action was not always recorded. Certain wound care and continence equipment was also out of stock.

There were offensive odours in the male unit and other areas of the home. Some of the décor and furnishings were worn and in need of updating. We had concerns about infection procedures at the home and certain areas of the home were not clean.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had the skills, knowledge and experience to provide care to meet the needs of the people who used the service. Staff were inadequately supervised and supported to do their jobs and care for people safely.

The requirements of the Mental Capacity Act 2005 were not met.

Staff did not always ensure people received a suitable diet and adequate amounts of fluids although improvements were noted during the last day of our inspection.

Referrals to health and social care professionals were not always carried out in a timely manner to ensure people's needs were met.

Is the service caring?

Inadequate

The service was not caring.

We observed that care was not always provided with patience and kindness and staff did not always promote people's privacy and dignity.

Staff had not been supported to ensure the way they worked empowered people to live as independent a life as possible.

There was a lack of evidence that people and their representatives were involved in planning their care.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

People did not receive personalised care that was responsive to their needs. They were not engaged in any meaningful activities.

Surveys and meetings to obtain the opinions and feedback of people and their representatives had not been carried out. In addition, the peripatetic manager was unsure whether any complaints had been received since none were documented.

Is the service well-led?

Inadequate 

The service was not well-led.

There was no registered manager in place and there was a lack of direction and supervision of care delivery and staff.

There was no evidence that any audits of the services being provided had been carried out. The peripatetic manager stated that none had been completed. Following our inspection, the provider contacted us and said that these had been completed and were held at head office.

There were serious shortfalls in the maintenance of records relating to people and the management of the service.

The provider had not submitted notifications to us in line with their responsibilities and legal requirements.

Cleveland Park

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.

Prior to our inspection, we received information of concern about the care and treatment of people. This related to specific safeguarding concerns, moving and handling procedures and pressure area care. We took this information into account when planning our inspection.

The inspection team consisted of five inspectors, an inspection manager, and a specialist advisor in nutrition. We also sought advice from a CQC pharmacy inspector.

We visited the home on 2, 9, 15, 16 and 22 October 2015. All visits were unannounced except the visit on 16 October 2015.

We spoke with the nominated individual, the regional operations manager, manager, peripatetic manager, two project managers, compliance officer, deputy manager, four nurses, three agency nurses, 15 care workers and the cook. We looked at 19 people's care records and staff recruitment and training files.

Most people were unable to communicate with us verbally due to the nature of their condition. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with four relatives.

We conferred with staff from the local authority contracts and safeguarding teams and the local Clinical Commissioning Group throughout our inspection. We also consulted two community matrons, a palliative care nurse and a community psychiatric nurse to obtain their opinions about the home and the care and treatment provided.

Prior to our inspection, we reviewed all the information we held about the home. We did not request a provider information return (PIR) due to the late scheduling of the inspection. A PIR is a form which asks the provider to give some key information about their service, how it is meeting the five domain areas of safe, effective, caring, responsive and well led and what future improvements they plan to make to the service.

Inadequate

Is the service safe?

Our findings

Prior to our inspection, we received information of concern about the care and treatment of people. This related to specific safeguarding concerns, moving and handling procedures and pressure area care. We took this information into account when planning our inspection.

At the last inspection, we found that there was a continuing breach of the regulation relating to the management of medicines. We issued a warning notice and told the provider they needed to take action to improve.

At this inspection we checked staffing levels. The peripatetic manager told us that prior to our inspection there had sometimes only been one nurse on duty to oversee the nursing needs of people who lived at the home through the day and night. Staffing levels were increased during our inspection when shortfalls were recognised. One relative told us, "The staff are lovely and I shouldn't complain they have a hard job but I wish they would stop always blaming the opposite shift. There's definitely not enough of them, they can't see to everyone at once."

We spoke with day and night staff who continued to express concerns about staffing levels. One member of night staff said there was often only one nurse on duty overnight to oversee the care of everyone with nursing needs. She said, "It's very, very dangerous. It is affecting our professional integrity as nurses. According to the NMC, I shouldn't be looking after so many [people]. I don't finish the tablets until 1am, because I am here and there. They [care workers] call me. A nurse cannot be two places at once. We just want to have the time [to look after people]."

The peripatetic manager informed us that three nurses had put in their resignation and were leaving. This meant that there would only be two permanent nurses employed at the home once these nurses left. She told us that they were actively recruiting nurses and care workers.

We saw limited interactions between staff and people during our inspection. Staff informed us this was due to staffing levels. One member of staff said, "It's not a normal nursing home. These people have complex needs and more staff are needed." We observed that people were not supported to have their position changed regularly and there were delays in providing continence care. On our first day there was no nurse available on the nursing unit for the first hour of our visit and we saw people who were very frail attempting to eat their breakfasts without any support or staff presence in the dining room.

We had concerns about the cleanliness of the premises. We spoke with a member of staff from the domestic team. She told us that there were often only two domestic staff on duty and three were required. We noticed that on occasions there was only one domestic on duty.

We concluded that there were insufficient staff employed and deployed to meet people's needs and ensure that environmental standards were maintained.

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

During our inspection, staffing levels were increased further to include two nurses on duty at night and six care workers. Through the day, staffing levels were increased to two nurses and 12 care workers with additional care staff deployed at peak times although this was not consistently maintained. The peripatetic manager told us that this was due to staff phoning in sick at short notice.

We checked medicines management and found that medicines were not administered in a timely manner. One person was complaining of pain; the nurse did not administer pain relieving medicine until three hours later. We observed that morning medicines rounds sometimes did not finish until after 12pm. One person who had diabetes did not receive their insulin until 11.40am. As a consequence their blood sugar levels had increased. Night nurses informed us the night time medicines round did not finish until after 1am if there was only one nurse on duty. They told us that people were asleep and some refused their medicines because of the lateness and delay in administering them.

A system to ensure the adequate stock of medicines was not fully in place. Medicines were out of stock on occasions including those for epilepsy and pain relief. The provider informed us that there had been issues with the ordering and supply of certain medicines by some GP practices and the pharmacy. The provider informed us that staff had contacted the GP practices and pharmacy to chase up any outstanding prescriptions. We noted however, that this action was not always recorded. Certain wound care and

continence equipment was also out of stock. This meant people were not receiving their medicines and prescribed equipment as they should have, to ensure their needs were met to prevent any deterioration in their condition.

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

The local authority had placed the home into 'organisational safeguarding' during our inspection. This meant that the local authority was monitoring the whole home since there were concerns that some of the practices within the service were putting vulnerable people at risk. The provider had referred three areas of concern to the police. We cannot comment on these at the time of this inspection. CQC will monitor the outcome of the safeguarding and police investigations and actions the provider takes to keep people safe.

There were safeguarding policies and procedures in place. Staff told us that they had not seen anything which had concerned them. However, when we had discussions with staff, they described incidents where people had been exposed to harm, such as physical altercations between people. This showed that staff awareness of safeguarding, and what to report and when, was limited and that they had not been adequately supported and supervised. In addition, one member of staff told us that she had raised concerns with the previous manager about another staff member's conduct. However, she did not think any action had been taken. We referred these concerns to the local safeguarding authority and informed the peripatetic manager of the service.

We had not been notified of any safeguarding concerns in 2015. We wrote to the provider using our regulatory powers to request information about any safeguarding procedures which had occurred at the home. The peripatetic manager sent in six notifications of alleged abuse. She had recorded on each notification, "There is no evidence within the home to suggest that the manager in post reported this incident to the safeguarding vulnerable adults team." This omission meant there was no evidence to show that correct actions had been taken following allegations of abuse. We found this had, in turn, placed vulnerable people at risk. The provider informed us that concerns about the lack of safeguarding referrals had been raised by one of their project managers.

The provider had organised for a full financial audit and found that systems were not in place to safeguard people from the risk of financial abuse. Incidents of financial irregularity are currently under review.

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

We spent considerable time looking around the premises. Some of the décor and furnishings were worn and in need of updating. There was a strong smell of stale urine and faeces in the male unit and other areas of the home. We visited one person in their room and noticed that there were faeces on the carpet and bedding. We checked another bedroom and saw that there was a stained uncovered sponge cushion on the floor in the en-suite bathroom. There was also dried faeces on the floor and wall. The light switch pull cord was stained. This was an infection control risk.

Some of the armchairs in the lounge areas gave off an offensive odour when we sat on them. Certain paintwork around the home was damaged which meant that these areas could not be cleaned properly which was an infection risk.

We observed that one person spat out their medicines. The nurse picked these up and did not wash their hands before continuing the medicines round. This meant there was a risk that harmful microorganisms could be transferred during the administration of medicines since handwashing guidelines had not been followed.

Staff informed us and our own observations confirmed, that equipment such as moving and handling slings, slide sheets and wheelchairs were shared. This was an infection control risk. In addition, there was a risk that this equipment may not be suitable since it has not been individually assessed to meet people's needs.

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

We checked equipment and noticed that some people were not sitting in appropriate chairs to support their health, safety, posture and comfort. In addition, pressure relieving cushions appeared worn. We were unsure how effective these were at preventing pressure ulcers. We

Inadequate

Is the service safe?

noticed that many of the wheelchairs did not have cushions fitted. This meant that equipment did not always promote people's comfort. Some staff told us that the weighing scales were inaccurate. This meant there was a risk that people's weight was incorrectly assessed. The compliance officer informed us that the calibration of scales to ensure their accuracy had not been carried out.

We observed several risks around the home which had not been assessed. There was a glass television cabinet stored in one person's en-suite bathroom. The en-suite bathroom was used and had a shower fitted. Glass shelving was also fitted which had sharp corners. This furniture and shelving posed a potential hazard should the person fall.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

We found that not all accidents and incidents were recorded or reported. We had not been notified of serious injuries prior to our inspection. We noticed that some people had sustained bruising and skin damage. The details of the cause of some of these injuries and the action taken was not always recorded. We identified that at least two people had sustained fractures which we had not been made aware of.

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

We looked at staff recruitment. We found that no references had been obtained in one of the staff files we checked and only one in the other. In addition, the nominated individual raised concerns that one member of staff had been working as a nurse on some of the shifts and was not registered with the Nursing and Midwifery Council [NMC]. This meant they were not qualified to work as a nurse. This member of staff no longer works at the service and this matter has been referred to the police.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Inadequate

Is the service effective?

Our findings

The training manager provided us with information about staff training. We saw that the majority of this training such as first aid had been delivered via e-learning and we did not see how staff understanding had been checked and validated. Individual learning and development plans were not in place and there was no evidence of mentorship tailored to staff's abilities and individual learning requirements.

We found concerns with staff practices in relation to pressure area care, continence care and nutrition and hydration. In addition, nursing staff told us that they were unable to carry out certain clinical procedures such as urinary catheterisation and venepuncture [taking of blood]. This meant there was a delay in people receiving healthcare since outside professionals had to visit the home to carry out these duties. One nurse told us, "I wouldn't carry out catheterisations now; I haven't done one for so long I wouldn't be competent." There was no evidence that nursing staff had carried out any clinical training or undertaken competency assessments in these areas or in key aspects of nursing care such as wound care and medicines management. This meant that nursing staff had not been supported to complete additional training to ensure they met the post-registration education and practice requirements set by the NMC to maintain their registration as a nurse.

The peripatetic manager informed us and records confirmed that individual staff supervision sessions and appraisals had not been carried out. One member of staff said, "I've never had an appraisal for three years." This omission meant that staff were not being supported to ensure that they could carry out their roles and responsibilities adequately and to an appropriate standard. In addition, there was no evidence of clinical supervision for nursing staff. Clinical supervision is a formal process of professional support and learning which enables nurses to develop their knowledge and competence. This omission meant that opportunities were not always available for nursing staff to be able to demonstrate that they had the professional standards and competencies needed to continue to practise as a nurse. We found that the manager had not received any formal one to one supervision, even though he had been unregistered with the Commission.

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

In England, the local authority authorises applications to deprive people of their liberty (DoLS). The peripatetic manager told us that only four people had an authorised DoLS in place despite the fact that the majority of people were living with dementia. Care plans did not evidence that a DoLS screening checklist had been undertaken to ascertain whether the plan would amount to a deprivation of the person's liberty. We also found there was a lack of documented evidence to demonstrate that care and treatment was delivered in line with the Mental Capacity Act 2005. We noted that a mental capacity assessment had been completed for one person. This was not decision specific and did not highlight that the person resisted all personal care, or what decisions had been made in their best interests to receive personal care. This meant that people's rights to make particular decisions had not been protected, as unnecessary restrictions may have been placed on them.

Most of the consent forms in the care plans we viewed had not been completed. This meant there was no evidence that people or their relatives, where people were unable to sign, had consented to the care and treatment which was planned.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We checked whether people's nutritional and hydration needs were met. One relative told us that their family member had lost "a lot of weight" when they moved to the home. They said that they now visited the home daily to assist them with their meals.

We noted that a number of people had lost weight. It was not clear what action had been taken in response to this weight loss and we found examples where specific professional advice had not been followed or where advice had not been sought when it should have been. We read that some people were at high risk of malnutrition, it was not clear however, whether a referral to the GP or dietitian had been made. Staff informed us that mealtimes were sometimes delayed. On the last day of our inspection,

breakfast did not finish until 11.50 in one unit. Lunch was then served at 12.30. One staff member said, "Obviously no one is hungry at lunch time because they have just finished their breakfast."

We spent time with people in each of the four dining areas. The television was on in one of the units that we visited and a chat show programme was showing. Some staff sat with people and encouraged and supported them to eat and drink. We saw that other people however, were left with food and drink in front of them. Staff did not encourage them to eat or drink and these meals were eventually taken away untouched.

Staff informed us that some people required special thickener in their drinks because they were at risk of choking. Some new staff informed us that they were unsure how much thickener needed to be added. One new staff member said, "They [staff member] said they needed two scoops, but I like to know the consistency, because two scoops may be alright in a smaller cup, but not in a larger beaker, it's important to know." Care plans did not always contain detailed guidance on what consistency of food and fluids were required to reduce the risk of choking.

We noticed that food and fluid charts were not always completed accurately. We read one person's chart which recorded that the individual had consumed two drinks of milk totalling 400mls. However, we had been with the person and noticed that neither cup of milk had been drunk and no attempt was made by the staff to encourage the person to drink them. None of the care records which we viewed had detailed nutrition and hydration plans in place which met people's individual needs. This omission meant that there was a risk that people would not receive adequate nutrition and hydration to promote their health and well-being.

Individual statements of health and well- being had been introduced on the 12 October 2015. These charts documented personal care, pressure area care and diet and fluids. We noted however, that these sometimes contained gaps and omissions in the recording people's care and treatment. We found that staff were completing these charts more accurately on the final day of our inspection.

We spoke with the cook and found they were unaware of people's dietary requirements and people's likes and dislikes. They were unaware of special diets and only knew how many pureed meals were required. They did not know about any potential interactions between food and medicines. One person's care plan stated that green leafy vegetables should be avoided since these affected the medicine they were prescribed. We found that staff also lacked knowledge about people's specific dietary requirements. We read that one person was a diet controlled diabetic. Staff were unaware of this diagnosis. This meant there was a risk that the person could receive a diet which did not meet their healthcare needs.

Night staff informed us that sometimes sandwiches were not prepared for them to give to people for supper. One member of staff told us that there was no hot chocolate or Horlicks to offer individuals. She said, "We are not giving people a good diet. It's so important to have a good meal at night time, it helps people sleep."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

On our fifth visit to the home, we saw that the provider's nutrition and catering expert was working with staff to ensure people received suitable and nutritious food. We saw that regular snacks were offered throughout the day. These included fruit, cheese and home baked cakes and biscuits.

We found serious shortfalls in record keeping. It was not always possible to ascertain if the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were being met, to maintain their health.

A palliative care nurse informed us that there had been a delay in obtaining medical advice regarding concerns that one person had not passed urine. We were concerned about another person's condition on the fourth day of our inspection. The provider's compliance officer asked the nurse to request a GP visit. At 2pm we asked whether the GP had seen this individual and found that a GP visit had not been requested. The GP was finally contacted following our intervention and the person was prescribed an antibiotic for an infection. A third person had been having difficulty eating and drinking for several days and there had been a delay in contacting the relevant health professionals.

Inadequate

Is the service effective?

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

The provider informed us that additional nurses were provided by them to support staff to focus on wound management and the completion of body maps which documented people's skin condition. In addition, these nurses helped complete malnutrition assessments.

At the end of our inspection, the peripatetic manager informed us that a number of referrals had been made to health and social care professionals; however we found these were not always documented.

Inadequate

Is the service caring?

Our findings

We noticed that some people looked unclean and unkempt. Many were just wearing socks without any slippers or shoes. This lack of attention towards people's personal hygiene and appearance did not promote dignity or respect.

We spoke with one relative who told us that she had asked staff to wash her family member's hands before she gave them some food. She said however, that their hands were still not clean and said, "Come and inspect his hands." We observed the person eating food when their hands were still unclean. The relative also said that she had been upset the day prior to our visit since her family member had a jumper on but was wearing no vest or socks despite having a "full wardrobe of clothes." She said, "He was always a smart man; wore his tie every day - even a Sunday when in the garden." This lack of attention to personal care did not promote dignity.

We saw staff moving one person in a hoist. Their underwear was on show and staff did not cover them with a blanket when they moved them to promote their privacy and dignity.

Some staff were very warm and caring and demonstrated good communication skills. We observed staff chatting and joking appropriately with people. One person became upset and was immediately supported by a care worker. The care worker said, "Would you like me to help you?" The lady replied, "No, I want him" pointing to a staff member across the room. The care worker made a joke about not being wanted which made the person laugh. Another individual also became upset and a care worker sat beside them which helped them to relax.

Some staff however, were task orientated in their approach to people's care. We saw a staff member remove an individual's clothing protector as soon as they finished their meal. They did not speak to the person and moved on to do something else. We heard another member of staff say, "Is someone feeding her?" A third staff member said, "You are not listening to me." These interactions did not demonstrate person centred care.

Staff informed us that hairbrushes and toiletries were shared. This did not promote people's dignity. In addition, it was an infection control risk. The provider's compliance officer organised for 50 bottles of shampoo and other toiletries and hairbrushes to be purchased during our inspection.

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

There was a lack of evidence to demonstrate that people or their representatives were involved in people's care. During our inspection, meetings were held with people and their relatives to inform them that concerns had been identified prior to and during our inspection.

We spoke with a palliative care nurse. She informed us that she had tried to set up a palliative care register at the home. She said however, that her requests had, "Fallen on deaf ears." The peripatetic manager explained that there was, "No end of life care" at the home. At the beginning of our inspection, staff were unable to inform us who was on the palliative care register or what plans were in place to ensure that people's needs at such a significant time of their lives were met. During our inspection, the palliative care nurse was working with the home to review people who should have been on the palliative care register.

Inadequate

Is the service responsive?

Our findings

We found serious shortfalls in care planning and risk assessment documentation. Information was not fully available to inform staff what actions should be carried out to ensure people's needs were met. During our inspection, some of the care plans and risk assessments were updated and reviewed; however, staff had not yet read these and therefore did not follow the guidance contained in the updated documents. One person's falls care plan had been rewritten, however, staff were not following the guidance which stated that one to two members of staff were required to support them and footwear should be worn.

There was no recognised tool in place in the care files we examined for the assessment of pain for those individuals who could not verbalise their feelings. One person called out frequently through the day. Her facial expression indicated that she could be in pain; however no assessment was carried out and no action was taken.

We observed that most people were left sitting in their armchairs in the lounges for lunch. This meant that some people had been sitting in the same position and in the same room for a

long time. Therefore there was no opportunity to socialise or experience a change of

environment during the meal time. One of the management team asked a care worker about this issue and who came to the dining area for their meals. The member of staff said, "Only the select few." It was not clear how the "select few" were chosen. We noticed that people were left sitting for long periods without being moved and their incontinence pads were not changed regularly. We concluded that people's physical needs were not attended to often enough to promote comfort and wellbeing and to prevent skin damage and the risk of pressure ulcers.

During our inspection, these practices began to change and more people were supported to the dining area for lunch.

On the second day of our inspection there was a physical altercation in one of the lounges between two people who lived at the home. Staff confirmed that these altercations were a regular occurrence for one individual because of their dementia related condition. We read their care file and noted that there was no care plan in place relating to their physical aggression. This meant that information was not available to inform staff what action they should take to ensure the safety of all concerned and help de-escalate any aggressive incidents.

Two staff who had come to support staff from one of the provider's other homes, spoke with us about their concerns that one person may not have passed urine for 48 hours. We read the person's health and wellbeing chart and noted there was no record that the individual had passed urine. Staff passed this information on to the nurse on duty and a palliative care nurse who was visiting the home checked this individual. She asked staff to contact the GP immediately since she thought the person was in urinary retention and would need to be catheterised. We had concerns about another person's catheter care. There was no care plan in place to instruct staff on how to manage the catheter, following previous complications. We saw that staff had not securely attached the person's leg bag to their leg which could cause damage.

One person had recently fallen on a number of occasions and sustained a serious injury. Staff were unable to confirm what action had been taken to reduce the number of falls, such as a referral to the falls clinic.

We read one person's care plan and noted that they had a number of pressure ulcers. The care plan stated that the dressings should be changed every three days. The care plan did not evidence that the dressings had been changed at this frequency. In addition, we read that the specified dressing had not been used on one occasion. This meant that the person's treatment was not carried out as planned. The continence nurse had assessed another person and prescribed special urinary equipment because of skin damage. We visited the person and found that this equipment was not being used. In addition, we noticed that their limbs were contracted and no special cushioning was in place between their contracted legs to reduce the risk of further skin damage.

On the last day of our inspection, the peripatetic manager told us that the tissue viability nurse had discharged one person from the tissue viability service because of improvements in their pressure ulcers.

We attended two morning staff handovers. Limited information was given to staff about people's care and treatment. Several people were on antibiotics; however the reasons for the antibiotic therapies were not given. Care

Is the service responsive?

workers were only given information about the people on the unit to which they were assigned. There was no further guidance provided by nursing staff of the specific tasks which needed to be undertaken, such as ensuring adequate fluids.

We spoke with the agency nurse who had been on duty the night of our third visit. They told us that the handover they had received when they came on duty "Was not very good." They informed us that they had not received an induction to the service. Day staff also expressed concerns about communication between shifts. One staff member said, "We don't get to know anything, the handovers are all wrong." Another stated, "When you've had a day off, it's a nightmare. You're finding things out as you go along." This lack of communication meant there was a risk that people could receive inconsistent or unsafe care that did not meet their needs.

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

An activities co-ordinator was employed to help meet the social needs of people who lived at the home. We saw that most people were sitting in the lounge areas in each unit for most of the day. There was little to occupy people's attention; some people spent time asleep. In the male unit there were several altercations between people who used the service. Staff told us that they had limited time to spend with people because of staffing levels. We did not see many organised activities being carried out during our inspection and did not see anyone access the garden areas except one person who smoked. Staff informed us that another person enjoyed going out into the local community. They informed us however, that these trips out had stopped because there was no care plan or risk assessment in place.

In several of the units staff closed the curtains in the lounge areas after lunch. We considered that this may be confusing for people since they may become disorientated to time. We saw that staff assisted many people into their night wear at 2pm and put them to bed. These people did not get up again that day. One new staff member said, "They put them all to bed and once they're there, they stay in bed." We visited one person in her room who was lying in bed. The radio had not been properly tuned in and was crackling and playing loud rap music. We visited a second person who was unable to get out of bed because suitable pressure relieving equipment and seating was not available. There was no television on or music playing; they were just staring at the wall. They told us that they were happy, but sometimes got "bored."

At the end of the inspection, most people were no longer getting ready for bed in the afternoon. People were getting up for tea and appropriate music was playing.

There was no evidence that people were supported to have a bath or shower regularly. One relative said, "I come in and sometimes they really stink - it's awful. They would want to be bathed every day, especially if they are incontinent." We spoke with staff about this issue. They told us that people were not supported to have a bath or shower as often as necessary because of staffing levels. We saw that one relative was shaving their family member's face in the lounge on our third visit to the home. She told us, "I have to do this, because night shift never do."

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

At the end of our inspection, staff were supporting more people to have a bath and shower. Most people looked cleaner and their hair had been brushed.

A complaints procedure was in place; however, the peripatetic manager was unsure whether any complaints had been received since none had been recorded. We spoke with one relative who told us that they had raised several complaints about their family member's care. There was no evidence of these concerns or what action had been taken to address these.

The peripatetic manager informed us that surveys had not been carried out. This meant that there was no evidence to demonstrate that the opinions of people and their representatives were sought and action taken to address any complaints or concerns.

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

Inadequate

Is the service well-led?

Our findings

The manager was present on the first day of our inspection. He had been in post since May 2014 but despite reminders to him and a warning to the provider, he was not registered with CQC. This issue is being followed up and we will report on any action once it is complete. The provider suspended the manager on 2 October 2015 and they resigned on 7 October 2015. A peripatetic manager was in charge of the home. They were supported by two project managers and a compliance officer.

Management staff were unable to confirm the exact number of people who lived at the home and whenever we asked for this information we received varying figures. This uncertainty represented a serious concern for safety should there be a fire or if someone were to abscond from the home. There was no overall summary of people's diagnoses and identified needs for staff to reference. There was a high dependency on agency staff. During our fourth visit to the home we noticed that a new staff handover form was in place which documented the names and care needs of people who had increased health and care needs. However, this information was not available for each person living at the service.

We spoke with care workers who told us that there had been no direction from their line managers. One care worker said, "There's no structure, we don't know what's happening." We saw that both nurses were not present to oversee care delivery for most of the day because they were busy administering medicines. One nurse said, "It can take 30 minutes to supervise some people to take their medication." Nursing staff were not present during the lunch time period to supervise the meal times. One agency nurse said, "It's so important to be around over lunch time, but I don't have time, I've been giving out medication." We spoke with the project manager about this issue. They told us that they had recognised that this was a concern and were training care workers to enable them to administer medicines which would free up the nurses to enable them to monitor care delivery.

The regional manager told us that meetings, known as "Flash meetings", were carried out daily with the heads of each department. However, we still found concerns that important information was not passed to staff during handover.

The peripatetic manager told us that there was no evidence that any audits or checks had been carried out to monitor the service. Following our inspection, the provider contacted us and said that these had been completed and were held at head office.

We found concerns with all aspects of the service. This meant that the provider did not have effective systems in place to ensure that they were able to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We used our regulatory powers to request an urgent action plan from the provider about what actions they planned to take to improve. We visited the home again following receipt of the provider's action plan on the 22 October 2015 and found that sufficient improvements had not been made to ensure people's health, safety and wellbeing.

We found serious shortfalls in the maintenance of records. Records were not in place for each accident and incident and certain monitoring charts such as turning records and diet charts were not accurately completed. On the first and second days of our inspection, body maps had not been completed for all skin damage. On the third day of our inspection, a nurse employed by the provider had completed body maps for all people which documented the extent of skin damage although the reason for the bruising and injuries was not always apparent.

Care plans contained basic information about people's needs. The information contained within people's care files was not always easy to find. We read that one person was at high risk of malnutrition; however, there was no evidence that the dietitian or GP had been informed. The project manager stated that this information was probably recorded in the person's daily records. This meant reading all the person's daily records for a year to find out whether a referral had been made.

There was no evidence that accidents and incidents were analysed to ascertain if there were any trends or themes so that action could be taken to reduce the risk of these events occurring again. We spoke with the provider's compliance officer who told us, "There's no evidence that lessons have been learned." This meant that action was not being taken to reduce the risk of further accidents and incidents.

Inadequate

Is the service well-led?

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

We found that the provider had not notified us of any safeguarding concerns in 2015; certain deaths of people who used the service and no serious injuries. The submission of notifications is required by law and enables us to monitor any trends or concerns and pursue any specific matters of concern with the provider. We sent the provider a request for information about these events and incidents using our regulatory powers. This issue is being followed up and we will report on any action once it is complete.

This was a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of service user deaths and other incidents.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not taken steps to ensure people were assessed and appropriately placed at the home. In addition, the provider had not taken action to ensure that staff were able to meet people's needs. Staff failed to plan and deliver care in line with people's needs and ensure they received treatment.**

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who used the service were not always respected. Staff did not promote people's independence.**

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider failed to ensure staff adhered to the requirements of the Mental Capacity Act 2005.**

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks had not been adequately assessed. This exposed people to serious risk of harm. People were not protected against the risks associated with medicines because the provider failed to have appropriate arrangements in place to manage medicines. The provider failed to ensure that staff maintained appropriate standards of cleanliness and hygiene which meant that people were not protected against the risks of infection. People living at the service were not provided with safe care and treatment.

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded; or protected from the risk of abuse.

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had not made appropriate arrangements for people to receive suitable nutrition and hydration.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Not all areas of the premises were well maintained.** **People who used the service were not provided with suitable equipment and sufficient quantities of equipment to meet their needs.**

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider failed to ensure people were supported to raise complaints or that when they did these were thoroughly investigated and recorded.**

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People who used the service and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place.**

This section is primarily information for the provider

Enforcement actions

The provider failed to ensure accurate records were maintained in respect of each person using the service and the management of the home.

Governance of the service was inadequate.

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to ensure the staff were supported and trained to meet the needs of the people who used the service. The provider failed to take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed and deployed on a shift by shift basis.

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider failed to ensure staff had the necessary qualifications, skills and experience which were necessary for the work to be performed and were fit to work at the home. Recruitment procedures were not operated effectively.

The enforcement action we took:
Following the inspection we took enforcement action and cancelled the regulated activities of 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures.' This meant that nursing care could not be provided at the service.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The provider had failed to notify the Commission of all deaths of people who used the service.**

The enforcement action we took:
We are taking enforcement action and will report on any action once it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had failed to notify the Commission of other incidents such as safeguarding incidents and serious injuries.**

The enforcement action we took:
We are taking enforcement action and will report on any action once it is complete.