Rose Brae Nursing Home Ltd

Rose Brae Nursing and Residential Home

Inspection report

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Bebington
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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

This was an unannounced inspection carried out on 24 and 25 February 2016 and the 1 and 9 March 2016. We carried out a previous unannounced comprehensive inspection of this service on 10 and 11 September 2015.

During our September visit multiple breaches of legal requirements were found. We found breaches in relation to regulations 9, 10, 11, 12, 13, 15, 16, 17 and 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. .The provider was rated as inadequate and placed in special measures. Services that are placed in special measures are inspected again within six months to ensure the significant improvements have been made to meet the legal requirements. During our visit we followed up the breaches identified at the September 2015 inspection.

Summary of findings

Rose brae Nursing and Residential Home provides accommodation with nursing and personal care for up to 30 older adults. The home is a converted three storey mature house situated in the residential area of Spital, Bebington. It is within walking distance of local shops and public transport. Accommodation consists of 29 single bedrooms and one shared bedroom. A passenger lift enables access to all floors for people with mobility problems. On the ground floor, there is a communal lounge/ dining room for people to use.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

During this visit, we identified continued concerns with the safety and quality of the service. **We found breaches in relation to Regulations 9, 10, 11, 12, 13, 14, 15, 17,18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.**

People were not protected from the risk of abuse. The manager and staff at the home lacked an understanding of safeguarding and the action needed to take to protect people from potential abuse. Two people had unexplained bruising which had not been investigated or reported to the relevant authorities. One person's personal care was undertaken with the use of the full body hoist due to incidences of challenging behaviour. The use of the hoist in this way meant the person's freedom of movement was restricted. This was potentially unlawful restraint.

Some people's needs and risks were not properly assessed, care planned or managed. There was insufficient information in peoples' files on how to keep people safe and meet their needs in a way they preferred. Dementia care planning was poor and support for people's behavioural and emotional needs inadequate. This meant staff lacked clear guidance on how to provide safe, appropriate person centred care.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had not been adhered to in the home. People's capacity to make their own specific decisions had either not been assessed or contained blanket statements that covered every and any decision the person may be required to make. There was no evidence best interest meetings took place routinely when specific decisions needed to be made or evidence that any least restrictive options were explored for any decisions about their care. This included decisions to deprive people of their liberty. There was no evidence that staff were trained to support people with these needs.

Medicines were not always administered safely. Medicines received by the home were not always properly accounted for and people did not always receive the medications they needed when they needed them. This meant the management of medications was unsafe.

People did not always receive adequate nutrition and hydration. One person was fed an inappropriate diet for some of their meals which increased their risk of a choking episode and one person went for an 18 hour period without anything to eat and drink. We saw that the way in which staff monitored people's dietary intake was ineffective in identifying people whose food or fluid intake was insufficient.

Bed rails and bed bumpers were in use but the bed rail bumpers did not fit the full length of the person's bed. This meant there were gaps that the person's head or limb could have become entrapped in. This placed the person at risk of serious injury. Pressure relieving mattresses were set at too high a pressure for some people which increased the risk of a pressure sore developing. The mattress would also have been uncomfortable. There were no checks in place to ensure that bed rails and pressure relief equipment was safe and suitable for use and staff lacked sufficient knowledge of either to keep people safe.

The temperature of hot water in people's room was either lukewarm or a scalding risk. No effective check of the water temperature was undertaken to ensure it was safe. This placed people at risk of harm. The provider also failed to have proper systems in place to monitor the risk of the water being contaminated with Legionella. This was despite, being told of the inadequacy of the current system at the last inspection.

Summary of findings

Staff recruitment was poor. Application forms were poorly completed and staff references in the majority were not verified. Where people had criminal conviction these were not properly considered prior to appointment. This meant the provider could not be assured that they were safe and suitable to work with vulnerable people. Staff training and supervision records showed that staff did not receive suitable training or adequate supervision in their job role.

Care staff worked in isolation from nursing staff for the majority of the time. Care staff were patient and kind but some staff practices were unsafe and did not always respect people's right to dignity, respect and privacy. Nursing staff were not a visible presence in communal areas where people were sat and were observed to be disassociated from people's care.

The service was not well led. There were no adequate systems in place to ensure the service was safe, effective, caring, responsive and well led. There were no effective care plan audits, medication audits, equipment and facilities audits, safeguarding arrangements or staff recruitment and training systems. At the end of our visit, we discussed the concerns we had about the service with the manager. They were unable to provide a satisfactory explanation as to why the issues we identified during our inspection had not been picked up and addressed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Immediately following this inspection, the provider made the decision to close the home and cancel their registration with CQC.

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.

Potential safeguarding incidents were not identified and appropriately reported in accordance with locally agreed safeguarding procedures.

People's individual risks in the planning and delivery of care were not properly assessed or managed.

Staff recruitment was poor and did not ensure persons employed were of good character and safe to work with vulnerable people.

Medication arrangements were unsafe. Some people had not received the medication they required and medication records were poorly completed.

Is the service effective?

Inadequate

The service was not effective.

The principles of the Mental Capacity Act 2005 and DoLs legislation were followed to ensure people's legal right to consent was respected.

Some staff were not suitably trained and had not received appropriate support and supervision in their job role.

People's nutrition and hydration needs were not always met safely. Records indicated that people did not always receive sufficient fluids to prevent dehydration.

Is the service caring?

Inadequate

The service was not consistently caring.

Everyone we spoke with said the staff were good and treated them well.

Staff were observed to patient with the people they supported but the number of meaningful interactions between staff and people who lived at the home were minimal.

Staff did not always support people in such a way as to protect their dignity and privacy. People's right to confidentiality was not always protected.

Is the service responsive?

Inadequate

The service was not always responsive.

People's needs were not always properly assessed prior to admission to enable safe care to be delivered on admission to the home

Care plans lacked information about the person and preferences and people did not always receive person centred care.

Some activities were provided but for the majority of the day, people sat and watched television.

Summary of findings

The provider had updated their complaints policy to include information on the organisations people could contact in the event of a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of effective monitoring systems in place to check the service was safe and of a good standard.

The management of staff in the provision of care was poor.

The manager and provider failed to ensure significant improvements were made in the way the service was managed in order to meet legislative requirements.

Rose Brae Nursing and Residential 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 inspection took place on 24 and 25 February 2016 and the 1 and 9 March 2016. The first and last day of the inspection was unannounced. The inspection was carried out by two adult social inspectors and a specialist advisor. Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with three people who lived at the home. We tried to talk to more people who lived at the home but they were unable to speak to us, so we observed their care. We also spoke with two relatives, the manager, the deputy manager, three nurses, four care staff and the cook. We looked at a variety of records including eight care records, recruitment records for two staff, the supervision records of 7 staff, 13 staff training records and 13 medication administration charts. We examined a range of policies and procedures and other paperwork relating to the quality of the service.

We looked at the communal areas that people shared in the home and did a tour of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found that the arrangements in place to protect people who lived at the home from potential abuse were inadequate. During this visit, we found no improvements had been made.

In two of the care files we looked at, there were body maps and daily notes in place to indicate two people at the home had unexplained bruising. There was no documented explanation of how the bruising had occurred or evidence that an internal investigation was undertaken to establish its cause. We asked the manager about this. They confirmed no investigation had taken place and no referrals made to the person's GP and social worker for further investigation. We asked the manager if they had reported the incidents as potential safeguarding events to the local authority safeguarding team and the Care Quality Commission. They confirmed they had not. It was clear from our discussions with the manager that no consideration had been given to the possibility that the unexplained bruising could be an indicator of potential abuse.

One person's care file stated they displayed challenging behaviour which placed them at risk of harm during the delivery of personal care. The person's care plan instructed staff to use a full body hoist during all care interventions to minimise the risk to staff. The use of the full body hoist meant that the person's ability to move freely during the delivery of care was restricted. There was no evidence that the person had consented to this or that the risks associated with the use of the hoist in this way were assessed. The use of the full body hoist as a possible means to control unwanted behaviours meant the person was potentially unlawfully restrained. Unlawful restraint is an unnecessary and unreasonable response to the risks involved in the delivery of care and is classed as abuse.

These incidences were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have, and implement, robust systems procedures and systems that made sure people were protected from abuse and improper treatment.

We looked at eight people's care files. Some of the risks in relation to people's care were assessed but some were not fully identified. Peoples' care plans lacked suitable risk management advice on how to prevent the risk from occurring. This placed people at risk of inappropriate or unsafe care. Similar inadequacies in people's care plan and risk management information were identified at our last inspection. Despite this, little had been done to address our concerns.

One person's care file indicated they were immobile and lived with a medical condition that caused uncontrolled body movements. The person was observed to have quite marked involuntary movements. We saw that this person had bed rails in place. People who have limited mobility or uncontrolled body movements are at specific risk of entrapment when bed rails are used. An entrapment risk means that a person's head or one of their limbs could get trapped in the bed rail. Entrapment can result in serious injury and death. We saw that there was a bed rail risk assessment in place but it was generic. It did not assess the risk of entrapment posed by the person's uncontrolled mobility and failed to identify the support required to reduce this risk. This meant the person was not protected from harm.

One person had swallowing difficulties that placed them at risk of choking and aspiration pneumonia. Aspiration pneumonia occurs when a foreign body, such as a small piece of food goes 'down the wrong way' causing a chest infection to develop. We found that neither of these risks were adequately assessed and managed. Staff had no guidance on the signs and symptoms to spot in the event of a choke or aspiration incident for example, coughing, difficulty breathing or, guidance on what to do should an incident occur.

During our inspection, we observed that this person coughed for a prolonged period of time after being fed an inappropriate diet by a member of staff. A nurse observed the person coughing but took no appropriate action to alleviate the person's distress.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

Some improvements to the décor of the home had been completed. For example the lounge and dining room area had new flooring but the majority of the safety related

Inadequate

Is the service safe?

issues we identified at our last inspection were still not addressed. We also identified a number of additional safety issues during this visit that raised significant concerns about people's physical safety.

We checked a sample of individual bedrooms and found all the beds had integral bed rails. Some people had bed rail bumpers in place whereas others did not. A bed rail bumper is padding that is used on bed rails to prevent injury and entrapment. The bumper should fit the full length of the bed rail to prevent injury. For those people who had bed rail bumpers in place, the bed rail bumper was too short. This meant there were gaps that a person's body parts could become trapped in which placed the person at risk of serious injury.

We looked at the care files of two people who were at risk of pressure sore development. We saw they had pressure relieving mattresses in place for the prevention of pressure sores. The settings on their pressure relieving mattresses were set at an inappropriately high level for the person's weight. For example, one person's pressure relieving mattress was set to accommodate a person of 100kg in weight, yet the person only weighed 37.5Kg. This placed the person at increased risk of developing a pressure sore and discomfort.

We could find no information about the type of mattress or the setting to be used in people's care files. We asked a staff member if the settings were checked. They told us that the nursing staff did this. When we asked the nurse, we were told "It is set when it first goes on, they should stay at that". They were unable to tell us what pressure the mattresses should have been on, to prevent a pressure sores from developing. It was clear no routine check of the safety and suitability of the equipment was undertaken to ensure people received appropriate pressure relief support.

By law, under the Provision and Use of Work Equipment Regulations 1998 (PUWER), employers have a duty to ensure that any work equipment operated or controlled by staff is right for the job, regularly checked and maintained to ensure it remains safe for use. This legislation applies to bed rails and pressure relief equipment. The provider failed to ensure this legislation was followed.

At our previous inspection, we found that the water in some people's bedrooms was at best lukewarm. This made it unpleasant for people to have a wash in. During this inspection, we checked the water temperatures again. In some bedrooms the water was still tepid as opposed to hot and in some it was extremely hot at 50 centigrade which posed a significant scalding risk. There is increased risk of serious injury or fatality when hot water used for showering or bathing is above 44 °C. We spoke to the manager about this immediately due to the serious risk of physical harm to people who lived at the home.

These incidences were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the premises and its equipment was clean, safe and suitable for purpose.

Systems in place to monitor the risk of Legionella in the home's water systems were still inadequate. It was obvious no action had been taken to address the concerns that we pointed out to the manager and provider at our last inspection. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. The provider failed in this duty of care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have systems and procedures in place to assess, monitor and prevent the spread of infection

We found that the cleanliness of the premises had been improved. Cleaning schedules were now in place and on the day of our visit the home was adequately clean. The provider's call bell system which was found to be poorly labelled at our last inspection was now appropriately labelled and the manager told us a new call bell system was due to be installed within the next four weeks.

At our last inspection, we found staff were not always recruited safely. We found the provider's recruitment process unsafe again at this inspection. We looked at the staff files of two new members of staff who had been employed at the home since our last inspection. We found that the manager and provider had failed to seek the necessary information to confirm that the persons employed where of good character and suitable to work at the home.

Inadequate

Is the service safe?

For example, the information about their education and employment history was not fully completed. References from previous employers were not verified and in some instances did not match the person's last period of employment. Criminal conviction checks were undertaken but for one staff member, this check identified that the person had previous criminal convictions. The risks associated with this were not assessed or considered prior to employment and no additional checks or safety measures were put into place to monitor this person's safety and suitability once employed.

This example were a breach of Regulation 19 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have robust recruitment processes in place to ensure only 'fit and proper' staff were employed to work at the home.

We found the medication arrangements at the home were still unsafe. We looked at the medication administration records (MAR) for 13 people who lived at the home. We found discrepancies in the majority of the records we looked at. Some peoples' medicines were given but were not signed for, and some medications were signed for but not given. This indicated that some people did not always receive the medications they needed.

For example, three people had not received their weekly dose of medication for the treatment of osteoporosis and one person received their vitamin injection six days late. We saw that one person had refused all of their prescribed medication for approximately two months but little action had taken by nursing staff to address this. This placed the person's health and well-being at risk.

One person had a medication handwritten on their MAR by a nurse. The booking in of this medication had not been double checked by another nurse to ensure it was correct. When we asked the manager about this, the manager told us this person was not prescribed this particular medication but could not explain why it was listed on the person's MAR. The person's MAR showed that they had been offered this medication on at least one occasion by a nurse.

One person medical notes stated they were allergic to a specific class of medicines. When we checked the person's MARs, there was no information in relation to this person's allergy. We saw that the person's admission information stated that the person had 'no known allergies. We asked the manager about this. They also did not know that the person had any allergy to this medication. This meant they had not used the person's medical information to plan this person's care appropriately to ensure that any medicine that they received was safe to administer to them.

These exampled demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the not all medicines were stored securely to protect people from risk or recorded appropriately when medicines entered the home.

After our visit, we shared our concerns about the quality and safety of the service with the Local Authority and the Clinical Commissioning Group (NHS). We also made safeguarding referrals to the local authority safeguarding team in respect of those people whose health, welfare and safety was at immediate risk.

Inadequate

Is the service effective?

Our findings

During our visit, we spoke with two care staff about one of the people they cared for. We found they had a general understanding of the care people required but neither had a full understanding of their needs. For example, both told us the person was immobile, yet their care plan stated they were able to weight bear and walk short distances and both staff member when asked told us the person was not diabetic. This was incorrect.

We spoke to an agency nurse on duty and found that they lacked sufficient knowledge of people's needs and care. This placed people at risk of ineffective and inappropriate care. For example, when asked them about one of the people who lived at the home, they told us were not aware of the person we asked about and therefore was not able to describe their care needs.

We looked at the training records of 13 staff, some of whom we observed in practice during our visit. We found that staff had not received sufficient or appropriate training to do their job role effectively. Only seven of the staff whose training records we looked at, had completed moving and handling and safeguarding training. Only six had completed training in food hygiene and infection control and only five staff were trained in first aid and dementia care. Four staff had not received any adequate training yet these staff members worked regularly at the home without appropriate supervision. This indicated the provider had failed to ensure that staff had the skills, knowledge and experience to meet the needs of people who lived at the home

We asked the manager why some staff had not received appropriate training. They were unable to provide a satisfactory explanation. At the last inspection, the manager did not have an effective system in place to monitor staff training to ensure staff on duty had the necessary skills and experience to provide safe and appropriate care. At this inspection, there was still no system in place and the manager was still unable to tell us what training staff had completed in respect of meeting people's needs.

We asked two staff about the support they received from the manager. Both staff told us they felt supported in their role. When we looked at staff supervision records however we found that some staff had received one to one supervision in their job role whereas other had not. Staff supervision on the whole was inconsistent and did not demonstrate that staff received adequate support.

During this inspection, we found the nurses on duty had little to do with the support people received, they were not a visible presence in communal areas and had little involvement with the care staff on duty. The manager was also not a visible presence.

Throughout our inspection, we saw that care staff tried hard to provide people with support. We observed some staff use unsafe moving and handling techniques, provide unsafe nutritional support and some staff failed to respect people's right to privacy and dignity. This showed the failure by the manager and the nursing staff on duty, to ensure care staff were properly supervised and supported at all times.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure staff received appropriate training, supervision and appraisal in their job role.

The environment plays an important role in how much a person enjoys their meal. It can affect how much the person eats and a relaxed, social atmosphere at mealtimes can have a positive impact on a person's health and well-being. We observed the serving of breakfast, lunch and tea. We found that the lounge environment, where people who needed support to eat and drink were sat, was chaotic. Staff assisting people to eat and drink made little effort to engage with the person supported and were often distracted by other people who lived at the home and staff. It was not an experience that promoted good dietary intake.

One person whose care file we looked at required a thick pureed diet with no bits or lumps present. On the first day of the inspection, we saw that the person was fed an inappropriate breakfast. They were given Weetabix and the person was observed to struggle and cough. When we checked the consistency of the Weetabix, we found that it had not been pureed down to enable the person to eat this safely. It was 'gluey' in texture and had just been made soft with milk. The person continued to cough intermittently for approximately 50 minutes.

Inadequate

Is the service effective?

We spoke to a nurse about this who told us "She doesn't normally have Weetabix. Porridge is better consistency. We are feeding at risk, when I'm on I'll feed them myself. They (the person) are safer with yoghurt".

At tea time on the second day of our inspection, this person was again fed an inappropriate pudding. This resulted in another episode of coughing. We checked the consistency of the pudding and found that it was mashed cake and cream which contained lumps that had not been pureed down appropriately in accordance with professional dietary advice.

On both occasions, the person was banged forcibly on the back by a member of staff in an attempt to dislodge any blockages and relieve the person's discomfort. A nurse observed the person coughing but took no action to intervene.

We saw that this person's food chart indicated several instances were an inappropriate diet may have been given. For example, toast and baked beans were recorded as having been given, both of which are not easily pureed. This person had yoghurt for pudding for nearly every meal and when we looked at this person's weight chart, we found that a weight gain and loss of 8kg had been recorded over the period of two month. Despite this, we found no evidence that any action had been taken to investigate this.

There were other instances during our visit, of poor nutritional care and food hygiene. For example, according to one person's food and drink chart they had gone approximately 18 hours between supper and breakfast without any additional drinks or snacks being consumed. This person's fluid intake prior to supper was recorded as 700mls. This was insufficient to maintain good hydration.

Guidelines issued by the Public Health Agency in 2014 recommends that the interval between people's evening meal and breakfast should not be more than 12 hours and that a suitable fluid intake of approximately 1200mls of fluids should be consumed per day to prevent dehydration. On the first day of our inspection, this person was observed to be in pain. The person was observed to be groaning and holding their head. One of the symptoms of dehydration can be a headache.

We checked a sample of other people's fluid charts. We saw that the amount of fluids consumed was sometimes totalled incorrectly and some people's fluid output sometimes exceeded their intake. We found that staff had no information on what daily amount of fluids was sufficient to minimise the risk of dehydration and no guidance on what action to take if person's fluid intake was low. This meant that the way in which staff monitored people's fluid was ineffective.

We spoke to a relative during our visit and asked if they thought the person who lived at the home got enough to eat and drink. They told us that they thought the staff at the home did their best. They said the person was always offered an alternative meal if they did not like what was on offer but they "Personally don't think they drink enough".

Some of the people who lived at the home were prescribed dietary supplements by their GP, for example thick and easy. Some of these vitamin supplements were given to other people at the home and not just the person they were prescribed for. This meant that people's prescribed supplements were not used solely for their benefit.

One person was observed to cough on consuming fluids thickened with thick and easy. We looked at this person's care records. The person's notes stated that the person was to have two scoops of thick and easy per 200 mls in their drink to enable the fluid to be at the right consistency for them to swallow. A staff member confirmed this. There were instructions pinned up in the kitchen that stated that the person was to have 1.5 scoops per 200mls. This meant there was a risk that the person would be given the wrong drink.

These examples were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to ensure that people's nutritional and hydration needs were always met.

The Mental Capacity Acts 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Inadequate

Is the service effective?

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our previous inspection, the provider failed to have suitable arrangements in place to ensure the MCA and DoLS legislation was properly followed. At this inspection, we found the progress made to meet this legislation was insufficient.

A person's capacity should be assessed when their ability to make a specific decision at a specific time, is in question. The MCA makes it clear that blanket statements that assess the person's ability to make several or all decisions are not acceptable. Capacity assessments are not intended to be a general assessment of the person's overall decision making ability.

We looked at the care files of three people who lived at the home, identified by the manager as lacking capacity. Only two of the people had had their capacity assessed and these were blanket statements. There was no evidence that the person had been consulted with or involved in this assessment and no evidence that any support had been given to enable them to participate. One person's capacity assessment showed that the person failed to satisfy the mandatory conditions of the MCA's two stage capacity test yet they were still assessed as lacking capacity in all areas of decision making and subject to a DoLs.

One person's medication administration records and daily notes showed that they had refused their daily medication for two months. For a person's consent or refusal to be valid they must have the ability to make an informed decision.

No assessment of the person's capacity to refuse their medication had been completed and there was little evidence that any best interest discussions with the person, other staff, their relatives or other professionals involved in their care had been undertaken in respect of their refusal. This meant the manager and staff at the home had no knowledge as to whether the person's refusal to consent was valid.

Bed rails were in place in all of the bedrooms we visited. Bed rails are used to prevent people accidentally falling, slipping, sliding or rolling out of bed but require formal consent for use. This is because in some cases they could be considered as a form of restraint as they restrict a person's freedom of movement. We looked at the care files of three people with bed rails in situ. Consent forms had not been signed in any of the files we looked at.

We asked the manager for a copy of the provider's mental capacity policy and procedure that ensured staff at the home were following legal requirements in the planning and delivery of care. We saw that the provider's policy stated "If you believe that there is a good reason to question a person's capacity, then you should complete a mental capacity assessment". It was clear that the manager and nursing staff at the home failed to follow this policy in order to ensure people's legal right to consent was protected.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

Inadequate

Is the service caring?

Our findings

At our previous visit, staff did not always have due to regard to people's right to dignity, privacy and confidentiality. We also found that positive meaningful interactions between people who lived at the home and staff were limited. We found no change to staff practice had been made to ensure people received dignified and respectful support.

During our visit, we did not see any significant interactions between people who lived at the home and the nursing staff. Nursing staff were not a visible presence in communal areas and were disassociated from the task of caring for people. We saw that people who lived at the home looked comfortable and relaxed in the company of care staff but that positive meaningful interactions were limited. Care staff were patient and kind when supporting people but were largely task rather than people focused. They provided support as and when required but social interaction with people who lived at the home was reserved primarily for when an activity such as a game of bingo was organised or care provided.

The conduct of some staff did not respect people's right to dignified and private care. For example, one person required their catheter bag to be changed and this was announced in a loud voice across the lounge by a staff member. Some staff talked amongst themselves when they supported people rather than, speaking to the person they were assisting. One person's toileting needs was discussed by two staff in the communal lounge on route to the bathroom and two people were assisted to eat with minimal interaction from the staff members concerned. During tea time on the second day of our inspection, we heard a person ask four times for staff assistance but their request for help went unanswered. These incidences did not demonstrate a consistently caring and compassionate approach to people's care.

During the afternoon on the second day of our inspection, people had access to a visiting hairdresser. People's hair however was styled in the communal lounge/dining area. This meant several ladies were sat with wet hair or under the hairdryer in an area frequented by other people who lived at the home, staff and visitors. This did not respect people's dignity.

We saw that care records contained photographs of the person on the front of the file. Some of these photographs had been taken in circumstances that did not respect the person's right to privacy or dignity. For example, some of these photographs had been taken when the person was asleep, which meant that the person was unaware that they were being taken.

A file which contained personal confidential information about people's emergency evacuation needs was available in the entrance area of the home for all to see. This file contained information about the person, their physical and mental health needs and contained a photograph of the person so that they person was easily identifiable to visitors to the home. We spoke to the manager about this, as people's confidentiality had been breached.

Despite speaking to the manager directly at our last inspection about the staff use of blue disposable gloves when serving food and assisting people to eat, we found some staff were still wearing blue gloves during mealtimes. This did not look very nice and did not promote a good mealtime experience for people who lived at the home.

These examples demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

A service user guide was available in the entrance area of the home. At our previous inspection, we had spoken to the manager about the size of the font type used, which was very small and not at all use friendly. No changes had been made to improve the presentation of the information so that it was easy for people to read.

Inadequate

Is the service responsive?

Our findings

At our previous inspection. We found care plans were written in appropriate language but lacked sufficient information about the person and their needs in order for staff to provide good quality person centred care. We found no adequate improvements had been made.

During our visit, two people were admitted to the home. Neither person had had a pre-admission assessment undertaken prior to their arrival. This meant the manager lacked sufficient knowledge about their needs and risks prior to their arrival in order to assess whether staff at the home had the qualifications, skills and competence to provide safe and appropriate care. Staff had no information about people's overall care needs or their preferences. This made it impossible for staff to know what person centred care these people required.

We saw that one person had their physical observations taken when they first arrived at the home. For example, blood pressure, pulse and oxygen saturation levels (SATS). We saw from their SATS information that their oxygen saturation level was 86% on air. This is very low. An oxygen saturation level of 95% and above is considered normal. This person's oxygen level indicated the possibility of pulmonary disease. When we looked at this person's admission information, we found no medical history information had been provided or requested in respect of this person's admission. This meant staff had no information on any potential underlying medical conditions that may have impacted on the person's health. Despite this, no immediate action was taken by nursing staff to request advice and further information from the person's GP.

We asked the deputy manager how staff knew what these people's needs and care were if they had not been assessed prior to admission. They replied "Not sure, better ask the manager".

We looked at the care files of a further six people who lived at the home. We saw that the provider had introduced a new care planning format that guided staff in the areas of care that staff needed to assess, risk manage and describe. We found that people's care plans still lacked adequate information about their care and their day to day preferences.

For example, one person had a letter on their file from the hospital with a specific diagnosis of a medical condition. This letter advised the home that a monthly physical examination was required for early detection of any further complications. There was no corresponding care plan in place to advise staff of this. When we asked the manager, they confirmed no care plan was in place but acknowledged that one should have been. This meant there was a risk that a decline in the person's physical health would not be identified quickly so that appropriate action could be taken.

One person had a medical condition that required them to have a special diet and six monthly blood tests. There was no information in the person's file relating to this. No medical history information was available and the person's care plan was incomplete. We asked the manager if the person's medical history had been requested to ensure that staff were aware of and able to plan the person centred care this person required. They told us no medical history had been requested. We asked the manager if the person had had their required blood test to ensure that their dietary needs were being met. They did not know. This meant staff at the home did not know whether the diet they were providing was meeting the person's needs safely.

Care plans contained some information about the person's likes and dislikes but we found that where preferences had been stated these were not always been respected. For example, one person was unable to verbally communicate but their care plan stated that the person did not like milky drinks. When we checked this person's food and diet chart, we saw that the person had been given milky drinks such as hot chocolate on numerous occasions. We spoke to the manager about this. They were unable to tell us why this had happened.

One person's pain assessment advised staff to monitor and record the effectiveness of their pain relief medication but did not advise staff how to do this. There was no evidence that any monitoring in relation to the person's pain levels was undertaken and on the first day of our visit, we observed this person in pain. We did not consider that this person received person centred care that ensured their pain was managed appropriately so they were comfortable at all times.

Inadequate

Is the service responsive?

Overall dementia care planning and the person centred planning for people's emotional needs and risks was poor. Where people had emotional needs or behaviours that challenged, there was no evidence they had been risk assessed and appropriate support planned.

For example, one person was described as prone to occasional physical aggression. There was no evidence that the cause of the person's distress had been explored or guidance given to staff on how to alleviate the person's distress when they became upset. We asked the manager if a behavioural chart had been put into place to record and monitor the frequency, intensity or triggers to these behaviours in order to assist with their management. They said "We usually put people on a behaviour chart to identify their predictability" but acknowledged that one was not in place. This meant staff had no guidance on how best to support the person when these behaviours were displayed.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure people were appropriately assessed and in receipt of person centred care that met their needs and preferences.

Records showed that people had access to medical and specialist support services as and when required for physical health conditions.

The home employed an activities co-ordinator. We saw that the home's newsletter promoted up and coming events for example, Chinese New Year, Easter celebrations and resident meetings. One the days we visited a session of bingo was undertaken and some of the ladies at the home had their nails painted by staff. For the majority of the day however people sat in the communal lounge watching television.

The provider's complaints procedure was displayed in the home and had been updated since our previous visit. It now contained the contact details of those organisations people could contact in the event of a complaint. There were still no contact details for the provider. We looked at the manager's complaints records and saw that all complaints received had been properly responded to. This demonstrated that people's concerns were listened to and acted upon by the manager.

Inadequate

Is the service well-led?

Our findings

At our last inspection, the management of the service was inadequate. This placed people who lived at the home and staff at potential risk of harm. Both the provider and manager were issued with warning notices to improve the quality and safety of the service by a set deadline. At this inspection we found that the requirements of these warning notices had not been met. Significant breaches of the regulations were still identified. This demonstrated that insufficient progress in reaching legal requirements had been made. This meant the service failed to be safe, effective, caring, responsive and well led.

We found that people's care plan and risk management information did not ensure people received safe and appropriate care. Staff still had no adequate information on how to meet people's health, welfare and safety needs in a way that they preferred.

The way in which new staff members were recruited required significant improvement to ensure persons employed were safe and suitable to work with vulnerable people. Staff members had not been appropriately trained to do their job roles which placed people at risk of receiving safe and appropriate care and support arrangements for both new and existing staff were still not consistently provided.

Throughout our visit, the staff team were pleasant and approachable. They were hospitable and polite and demonstrated a positive attitude. They worked however, in the majority unsupervised by senior staff. No improvements had been made to the way they were managed to ensure accessible and appropriate support for people at all times. During our visit, we saw that the way in which some support was provided did not respect the choices, dignity and privacy of people who lived the home. These were on-going concerns from our last inspection and little managerial action had been done to address them.

Medication arrangements were still unsafe. The way in which medicines were booked into the home and returned to the pharmacy were not properly checked. This meant mistakes were made. The recording of the administration of medication showed discrepancies that meant the manager and provider could not be confident that staff had administered medication safely or that people had received the medication they needed.

We looked at the medication audits undertaken in December 2015, January and February 2016. We saw that where issues were identified, there was no action stated for how this would be corrected and no evidence of any action having been taken. For example, the audit in December 2015, asked if the balance of medication from a previous medication cycle was carried forward onto people's new medication administration chart. This was answered' No' but no action was stated. When we looked at people's MAR charts, we saw that some carried forward medications were still not properly recorded.

The system in place to monitor people's nutritional needs was ineffective and inaccurate, making it difficult for staff to tell whether people's intake was sufficient and the equipment in place to support people's needs had not been checked to ensure it was safe and unsuitable. The manager told us that they did mattress audits monthly. We looked at the audits undertaken by the manager in December and January 2016. We saw that the audit simply checked whether the bed was in good condition. No check was made to ensure that people's pressure relieving mattresses were on the right setting or that no gaps existed between the bed rail, the bed and the bed mattress which could pose an entrapment risk to people who lived at the home. This meant the audit was ineffective and did not pick up the safety concerns we identified during our visit.

These examples demonstrated that the home still required significant improvement to be considered well led. This was a continued breach of 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accident and incident audits were undertaken to identify any trends in how, when and where people fell. From these audits we could see that appropriate action had been taken in relation to any accident or incidents that had occurred.

We saw that a resident meeting had been held in November 2015 and January 2016. We looked at the minutes of these meetings and saw that people were given information about the running of the home and any forthcoming activities or events. A satisfaction questionnaire had also been undertaken in November 2015 with people who lived at the home and their relatives. We saw that in the majority, people's feedback was positive. These opportunities enabled people to feedback their views on the service provided.