Careline Lifestyles (UK) Ltd

Deneside Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this comprehensive inspection of Deneside Court on 28 July followed by 29 July, 4 and 11 August 2016. The first three days of the inspection were unannounced which meant that staff and the registered provider did not know we were visiting.

We had previously carried out a focused inspection of Deneside Court in March 2016 following concerns raised by external health and social care professionals and the police. During the inspection a breach in one of the legal requirements was found. The provider had failed to take appropriate steps to ensure staff were trained to provide safe and effective care to people at all times.

We asked the registered provider to send us an action plan outlining what steps they would take to ensure the home complied with Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They told us the actions would be completed by 30 June 2016. We took this action plan into consideration during this inspection.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service does have a manager who is new to post. They told us they intended to submit an application for registration with the Commission. The manager was being supported in the service by the area manager.

At this inspection we found that there were breaches of six of the Fundamental Standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, person centred care, consent, safeguarding, staffing recruitment and the overall oversight of the home.

Deneside Court is a 40 bed purpose built home and provides residential and nursing care to adults with learning disabilities and physical and neurological disabilities. At the time of the inspection there were 36 people using the service. The home was divided into three units. The ground floor unit comprises of 20 individual apartments with ensuite facilities. While the two upper units comprise of 20 self-contained flats which each contained kitchen facilities.

In addition to the above dates two pharmacy inspectors visited the service on 1 August 2016. This was to enable a full inspection of the registered provider's management of medicines procedures as we found the oversight and management of medicines was not safe. There were errors in the administration of medicines. Records for stock balances were not accurate. Medicines were being used that were past their use by date. Emergency medicines were not available for people who may have required emergency administration.

Although we found medication audits which identified issues the registered provider had failed to action these.

People's risk assessments were generic and risks associated with people's conditions for example, epilepsy, were not considered. Risk assessments were not subject to review in line with the changing needs of people or in line with the provider's own prescribed timescales.

Staff did not always have the appropriate training and skills to meet the needs of the people living in the service. For example, diabetes, learning disabilities and mental health needs. There was a lack of suitably skilled and experienced nursing and care staff permanently employed and the registered provider relied on temporary agency staff to provide nursing care and support on a day to day basis. They had failed to check that agency nursing staff had the skills and competencies to deliver the care and treatment people needed, such as tracheostomy care and support with behaviours that challenge. Staffing levels and skill mix were not always at a level determined by the provider's dependency tool. Staffing rotas were not always updated with changes.

The registered provider failed to have systems in place to ensure staffing levels were appropriate. They used a basic system of number of people to ratio of staff, which did not relate to the actual dependency of people who used the service or placing authority contractual agreements.

Staff told us they did not feel safe when supporting people with behaviours that challenge. We found the system for summoning support may not be appropriate to keep people and staff safe during periods of heightened behaviours.

We found that the staff had a limited understanding of the Mental Capacity Act 2005 (MCA) and what actions they would need to take to ensure the home adhered to the MCA Code of Practice. We found there were no capacity assessments even though evidence suggested some people might lack capacity.

We found that the main body of the care records, such as support plans and risk assessments were not person-centred. We saw generic templates were used and at times these referred to the person in the wrong gender so we could not be assured they had been created for the specific individual. Care records were kept in the nurse's office which was not always locked. This meant that people's personal care records and information was not stored appropriately to promote and ensure confidentiality.

The registered provider had ineffective systems for monitoring, assessing and reviewing the service. Where systems had identified poor practice, gaps in care practices or the need to make significant improvements, these were not always acted upon. Action plans we viewed contained timescales which had lapsed with outstanding actions remaining.

The manager was new to post and was being supported by the area manager. Both acknowledged that areas of the service need improvements to be made. The registered provider was in the process of holding a recruitment drive.

People told us they were given a choice of meals. One person told us, "It's alright, but I go out and eat as well." People were encouraged to prepare their own meals as part of their support plans.

We found evidence in care records to suggest referrals were made to community services when necessary and of visits by health care professionals including dieticians, community psychiatric nurses and advocates.

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 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.

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.

Medicines were not managed safely. People's records were not clear to demonstrate that medicines were administered. The ordering system was not effective. The stock balance of medicines were not accurate.

People's risk assessments were generic and risk associated with people's conditions for example, epilepsy, were not considered. Risk assessments were not subject to review in line with changing needs of people or in line with the provider's own timescales.

Staffing levels were not always at a safe level. Units across the home did not always have an appropriate amount of staff on duty.

The provider did not review training or competencies of nurses who were being supplied by an agency. Where staff are supplied by an agency, they become staff of the service therefore should be subject to the same checks as directly employed staff.

Is the service effective?

Inadequate

The service was not effective.

There was a lack of suitable skilled and experienced nursing and care staff employed and the registered provider relied on agency staff to provide nursing care and support on a day to day basis. They had failed to check that agency nursing staff had the skills and competencies to deliver the care and treatment people needed

The provider did not always act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

Health care professionals were involved in people's care. For example, GP's and community nurses.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff told us they would like to do more with people who used the service but that they did not always have the resources to do so.

Staff treated people with dignity and respect.

The service had information relating to independent advocacy, along with brochures about the service and the facilities the home offers.

Is the service responsive?

Inadequate

The service was not responsive.

Care records, such as support plans and risk assessments were not person-centred. Generic templates were used and at times these referred to the person in the wrong gender so we could not be assured they had been created for the specific individual.

The service made referrals to community services when necessary and of visits by health care professionals including dieticians, community psychiatric nurses and advocates when necessary

Is the service well-led?

Inadequate

The service was not well led.

Systems for monitoring, assessing and reviewing the service were ineffective. Where systems had identified poor practice, the gaps in the care practices or the need to make significant improvements, actions were not always completed in a timely manner.

The registered provider failed to have systems in place to ensure staffing levels were appropriate. They used a basic system of number of people to ratio of staff, which did not relate to the actual dependency of people who used the service or placing authority contractual agreements.

The manager is new to post and was being supported by the area manager. Both acknowledged that areas of the service needed to be improved.

Deneside Court

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.

The inspection took place on 28, 29 July and 1, 4, 11 August 2016. The first four visits were unannounced.

The inspection was conducted by two adult social care inspectors, who were accompanied by an expert by experience and a specialist advisor who is a Primary Health Facilitation Nurse Specialist with the NHS (National Health Service). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The inspection team also included two pharmacy inspectors.

Before the inspection, we reviewed the information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also gathered information from South Tyneside Council Safeguarding, South Tyneside Clinical Commissioning Group, South Tyneside Council Commissioners and South Tyneside Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we observed staff interacting with people and looked around the premises. We spoke to the area manager, manager, an administrator, six nurses, 13 support staff, one ancillary staff member and the rehabilitation assistant.

We spoke with 11 people who used the service and, as some who lived at this home had complex needs, we spoke with relatives for their views on the service.

We viewed a range of records about people's care including medicine administration records and how the home was managed including recruitment, training records, dependency tools, quality audits and statutory notifications.

Inadequate

Is the service safe?

Our findings

We looked at the systems in place for medicines management. We assessed 19 medicine administration records (MARs) and looked at storage, handling and stock requirements. We found that appropriate arrangements for the safe handling of medicines were not in place.

The nurse showed us the arrangements for destruction of not required or refused medicines. Although a contract was in place for the disposal of medicines we found that medicines were not disposed of safely on floor one. The nurse could not find the destruction record book during our visit. This meant that the nurse could not document the medicines not administered during the morning medicines round. The container used was not one supplied by the waste company and did not meet waste regulations as prescribed within the Department of Health Environment and Sustainability Health Technical Memorandum 07 – 01: Safe management of Healthcare waste. This was unsafe practice.

The majority of MAR charts were printed by the community pharmacy. Where handwritten entries of medicines were made, two nurses did not always sign the MAR, which was not a safe practice in line with guidance. The homes policy stated that all MAR records should have a photograph of the service user to aid administration; however, we found three records that did not have a photograph present.

We checked the processes in place for stock balance and ordering of medicines. The ordering system used at the home was not effective. We found that pain relief medicine for one person had been out of stock for four days and had been delivered the day prior to our inspection but not logged in so still appeared out of stock. We saw that two eye drops for one person, with a short shelf life once opened, were still in use after the date recommended by the manufacturer. This meant that this medicine was not safe to administer. Carried forward balances, which were used at the start of the medicines cycle to ensure accurate records of stock levels, were not always completed accurately.

Administration signatures on the MAR charts did not match with the quantities of boxed medicines. The home had a boxed/bottled medicines balance sheet, which they used alongside the MAR to ensure stock accurate recording however, this was not used correctly and did not record all administrations. The countdown figures did not tally and the final quantities did not match what we found in the trolleys for most medicines we checked. When 'as required' medicines were given these were not always recorded on the back of the MAR as detailed in the medicines policy. This meant staff were unaware why they had been administered and if they had been effective, this is unsafe practice.

Medicines which were prescribed with a variable dose did not always have the dose recorded during administration so staff could not be sure of the total quantity administered in a 24 hour period. When medicines where not administered the appropriate code was not always recorded to demonstrate why the medicine had not been given.

We reviewed four care plans specific for medicines. We found that the care plans were not up to date or reviewed at the appropriate frequency. We found one care plan could not be acted upon, as the medicine

stated for use if a resident experienced a hypoglycaemic event, was not available. A hypoglycaemic event is when a person suffers low level of glucose in their blood causing symptoms such as trembling, sweating and can cause the person to lose consciousness. A second care plan stated, 'if inhalers were repeatedly refused then the GP should be contacted for a review.' We found that the inhalers had not been used for several days yet no referral to the GP had been made. A third care plan stated that when the person suffered an epileptic seizure a medicine was to be administered for three days post seizure. However, we found from the balance count and the stock available that this care plan had not been followed.

We looked at the systems in place for covert administration. Covert medication is the administration of any medicines which involves disguising the medicine in food or drink. As a result the person is unknowingly taking medicine. We did not see the required documentation listed in the homes policy. Risk assessments were not specific to which medicines could be given covertly and no advice had been documented regarding the appropriateness of the medicines for covert administration. We were shown a best interest decision for one person from December 2014 which had not been reviewed to ensure it still reflected the person's needs. We saw evidence of an incident involving covert administration but this had not been reported as a significant event and could not be investigated so that actions could be taken to prevent re-occurrence.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the home had completed a medicine audit in July 2016 it was not robust and had not identified the issues found during our visit. A previous audit from May 2016 identified similar issues to those we found; the provider had failed to act upon these findings and draw up an action plan to address the issues.

We reviewed the care provided to people who were fed via a percutaneous endoscopic gastrostomy (PEG). A PEG is a tube which is passed into a person's stomach to provide a means of providing nutrition when oral intake is not adequate or possible. We found that the service did not reference the type of feed, how to give the feed and amount to be given in each person's care records yet some of the care staff were expected to provide the feeds. We asked staff about the type of feeds and found that for one person the care staff who gave the feed were unclear about how to provide it. Initially they could not explain what the type of feed was called or how it was administered. The nurse on duty told us the feed was not administered via a pump and one member of care staff said, "We squeeze the feed in down the tube". One of the agency nurses could explain it was a bolus feed and how to position the feed line to ensure it was delivered at a safe pace, but they only completed one shift at the home. We were concerned about this lack of understanding as in this person's notes the regional PEG nurse had written that they had again explained to staff that the feed flow was too fast and this was causing the person to feel sick and was placing them at risk of aspiration.

We also found that the system in place for checking if people had received their PEG feeds was ineffective. We found that the staff did not keep an accurate record of the amount of PEG feeds on site. We found that on the MARs we reviewed for one person there were two gaps in recording when the feed should have been administered. The lack of an accurate count meant we could not confirm that these feeds were given.

One person had a tracheostomy in place. A tracheostomy in an incision in the windpipe which allows a person to breath without the use of their nose or mouth. The tracheostomy required regular suctioning and another person was at risk of aspiration and needed to have excess fluids removed via a suction machine. There was one suction machine on the unit. For the person with the tracheostomy in place there was a generic care plan template in place that detailed how to manage the care of this site but we were unable to verify its accuracy. This was because none of the care staff we spoke with could tell us about the detail of the care plan and the nurses we spoke with did not to refer to the plans, as they described different procedures

for completing the tracheotomy suction. We also found that one of the agency nurses on duty responsible for caring for this person had not received tracheotomy training or a competency check for some five years. For the other person there was no care plan in place to detail when and how the excess fluid was to be removed.

We found that the care records although extensive used generic templates and were contradictory. Care staff and agency nurses told us that they did not look at the main care records because they were unhelpful and just looked at a two-page summary sheet. Staff said, "I never look at the main files as they are confusing and to be honest really unusable." We found that these summary sheets were not always an accurate depiction of someone's needs. Also vital information was not contained in the assessment or support plans such as people having peanut allergies, people were no longer able to walk about or were experiencing significant changes in their health conditions.

We reviewed the daily records staff completed such as positional change charts, food and fluid balance charts and records of when physiotherapy equipment such as wrist splints were used. These records were often completely blank although people needed all of the records filling in on a daily basis. This meant we could not be sure that people were receiving appropriate support and care to meet their needs.

We also found that staff were not meeting people's needs at times either because of a lack of staff or staff not being trained to undertake the task. For instance, one person's care record noted that they needed two hourly positional changes but no record was maintained to show if these had occurred. We saw positional change records in their file but these were blank. We saw in their professional visitors record that the staff had needed to contact the person's GP as they had developed sores on pressure areas. We asked four of the staff working on the unit about this and they could not tell us how often positional changes were required for this person and the other people on the unit.

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

Some of the care staff told us they were frightened by the behaviour of some of the people who used the service and this led to them not attempting to de-escalate behaviour and thus leaving situations to deteriorate to the point the police needed to be called. We found that although staff had physical intervention training, the registered provider's policy did not allow the full range of interventions to be used. This meant staff could not fully contain the incidents of aggression. We found that the registered provider was not ensuring all nursing staff working on the units where people could present with behaviours that challenge had appropriate physical intervention training. This had led to care staff being responsible for the management of individual's behaviour without being appropriately trained. The registered provider had not considered the risks posed to people from the use of any physical intervention or the risk of the people or care staff being injured during any intervention.

Staff told us about various incidents that had occurred on the units when people had become physically and verbally aggressive. One staff member told us, "I would not put myself at risk, so I would not use MAPA training." Another told us, "The right staff need to be on the right unit at the right time." They then explained that there were occasions whereby some staff were afraid of the residents and their work then became ineffective on the unit as they avoided undertaking certain tasks. A third told us, "If behaviours start, males normally take over, but there is not always a male carer on duty." We found one person's care plan stated, 'I may be physically aggressive to staff and I may lock staff in a room with myself.' We looked at the system staff had available to summon support. The home has a fixed single point alarm system. This does not provide an adequate control measure for staff who may not be able to reach the static alarm. This meant

that staff and people were not protected from potential harm.

We examined the safeguarding, accident and incident records. We asked for the analysis which was carried out to identify any trend of contributory factors which may require investigation. The last analysis for accidents provided by the manager was dated 05/10/2015. This meant that the provider had not carried out an analysis on a regular basis despite numerous recorded incidents.

The safeguarding analysis document was dated 03/06/2016. No lessons learned were recorded despite comments about trends and action taken from trends being recorded. This meant we could not be sure that the service was learning from incidents.

Staff said, "There is no cleaner and hasn't been for a while so we have to do this as well as look after the people." And, "The bins are around the back and to get there we have to go around the outside of the home. The bins are kept in a shed and this is really dirty so much so we had mice in there and they came in the home." And, "We often run out of yellow bags."

We found that the exterminator had been used to eradicate mice from the laundry. This was concerning as the laundry was on the first floor so it would be reasonably expected that the rodents could have travelled through large parts of the home but no action had been taken to determine if other areas were affected. Care staff completed all laundry tasks and this included contaminated linen in red bags but there was no appropriate personal protective equipment (PPE) for them to use in the laundry. From our discussions it was clear that not all care staff were aware that the linen in red bags needed to be washed separately from other linen. Some of the people who used service were being barrier nursed because of infectious diseases. These people's linen was placed in the red bags and if their linen was washed inappropriately there was a risk that other people would develop these infections. We discussed this with the manager and that the staff were removing rubbish, including clinical waste, through the main entrance to access the bins. Finally we noted that staff were not following the guidance around undertaking barrier nursing so did not use PPE or wash their hands in line with expected practice. Not all staff had a clear understanding of safe hand washing following intervention with someone who required infection control procedures to be followed. They told us they could wash their hands in the kitchen sink. The manager told us they had been unaware that these problems existed. This meant that staff and people were not protected from the risk of cross infection as laid out in NICE guidelines March 2012 - Healthcare- associated infections: prevention and control in primary and community care.

We asked for the dependency assessments that the provider completed to determine staffing levels. We found that these were dated February 2016; the document did not contain a review date. We found several of the assessments were not fully completed. For example, where people had specific needs such as learning disabilities, Parkinson's disease. The section for 'training required in full to care for this service user' did not contain details of the specific training staff had undertaken to ensure they could deliver safe care to people living with learning disabilities or Parkinson's disease. This meant that we could not be sure that the staffing levels were appropriate to people's current need and that the staff skill mix was such that could provide such specialist care.

We reviewed the current week's rota and recent weekly rotas. We found the service used a large amount of agency staff, both nurses and care workers. We asked for clarification that agency nursing staff on the rota had the appropriate training to meet the needs of the people using the service. For example, MAPA training (this is a special type of training used to assist people who have behaviour that challenges). The area manager told us, "We ask for specifically trained staff when we book nurses with the agency. We can check their PIN (a personal identification number that nurses have to demonstrate they are registered with the

Nursing and Midwifery Council to practice as nurses) and training records." We asked for a copy of the training records from the agency, these could not be located so copies were requested. When these arrived we found that the nurses on duty for 29th, 30th and 31st July did not have the appropriate training. We brought this to the attention of the area manager who advised nurses would be drafted in from a sister home and the agency staff from Deneside Court would be deployed into that home. On the third day of the inspection we found the same issues with the agency staff not being appropriately trained. Again this was brought to the attention of the management. They told us that staff would be deployed to ensure appropriately trained staff were on duty. This meant that that management had not checked agency staff's training status prior to them undertaking employment.

On day three of the inspection staff reported that staffing levels were short on one of the units. We found that staff were to be deployed from another unit in the home to address this; however this was not identified on the rota. This meant that staff did not have an up to date staffing rota to refer to. Staff said, "I have never had training around PEG feeding or vent care (a procedure used in tracheostomy care) but am left on my own on this unit and the people here have these needs. I think this is really unsafe and I am worried that something will go wrong." And, "I had to do a nightshift on my own on this unit, which can't be safe as most of the people need two staff to attend to all their care needs. We have told the managers about this but they do nothing. In fact one person put a grievance in and no longer works at the home so we don't feel able to say about our concerns anymore."

We spoke to relatives and staff about staffing levels. One relative told us, "Sometimes staff shortages are an issue and this can affect the caddy (organisation)." Another commented, "I'm concerned about the management structure as three senior managers had recently left and the lack of understanding the new staff have regarding [relatives] needs." We received mixed comments from staff. One staff member told us, "I am put in a compromising position regarding staffing levels." Another commented, "There is not enough staff, we have someone who needs one-to-one care, if we are short then others can't go out. One person becomes agitated and causes others' anxieties we can have up to four different behaviours at the same time."

Another told us they felt that whilst there was sufficient staff to manage the building there was not enough staff to take residents out. We spoke to one nurse who told us they felt the shift was safe. They then went on to tell us, "I have not vented (for a number of years so observed the nurse before she left." This meant that staff on duty were not competency checked to deliver safe care.

We found that the numbers of available staff were insufficient to meet the needs of the people who used the service. One of the service users who lived on the top floor required one-to-one support because of the level of behaviours that challenge they displayed. There accommodation was isolated and previously they had received two-to-one support. We found that the registered provider had not considered the impact the reduction in staffing levels may have upon the safety of the staff or the person and no system was in place for staff to quickly call for help. Staff, should they need assistance in an emergency, had to go into the person's flat and use the call alarm. The person could be assaultive and it was therefore questionable as to whether staff would be in a position to use the call alarm. Also, staff on other units told us that they, at times, could not respond to calls from other units because they were too busy plus the person tended to frequently set the emergency alarm off so they were never certain when staff genuinely needed assistance.

Overnight on the first floor two staff were on duty in each of the two units. We found that the people on these units had complex needs and could display marked levels of challenging behaviour. Also people smoked and needed staff to accompany them to the designated smoking area outside of the home, which left one member of staff on a unit. There was no floating staff to cover these changes and the staffing levels

did not meet the agreed staffing levels described in people's placement contracts. We also found that downstairs overnight there were insufficient staff to meet people's needs. On the one unit the majority of people required 2:1 support for all care interventions, individuals needed assistance to regulate their breathing and were confined to bed so required regular positional changes. However, often there were just two staff members on this unit. The nurse tended to be based on the other unit with one staff member so again at times one staff member was overseeing a unit.

The manager told us this met the registered providers staffing expectations and told us this was based on the number of people in the home not, as we would expect on the needs of the people and any contractual agreements.

We saw from the registered provider's staffing analysis they calculated that an 'additional 89 hours were needed to provide one-to-one support' but in the actual detailed breakdown showed that 14 people received one-to-one support and for them 856 hours were needed. Also on the staffing needs summary they had produced it stated 853 hours of one-to-one were needed each week. One-to-one hours are expected to be provided above the basic staffing numbers. It is expected that the staff on one-to-one support stay with the identified person and do not provide support to others.

The provider had determined from these figures that two nurses were needed at all times and 22 care staff were needed during the day and eight care staff were needed overnight. We found that a minimum of 14 staff were needed at times during the day and at least one person needed this one-to-one support overnight. This meant that ten staff, inclusive of the nurses, would be available across three floors and five units to provide support for the remaining 22 people during the day and seven staff were available overnight.

In effect, two staff could be based on each unit during the day and overnight two units could have two staff and the remaining units would only have one staff member to provide all the care for the people.

We found that over a third of people required two staff to assist them to attend to their personal care needs and a third needed at least one staff member to assist them. We concluded that there was insufficient staff deployed to safely meet people's needs at Deneside Court.

We looked at the provider's recruitment processes. We found the provider was not reviewing training or competencies of nurses who were being supplied by an agency. Where staff are supplied by an agency, they become staff of the service therefore should be subject to the same checks as directly employed staff. This meant that the recruitment process was not robust enough to ensure only suitably trained and competent staff are used to meet the needs of the people using the service.
This was a breach of Regulation 12 (Safe care and treatment) and 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that medicines were stored securely and the keys were held by the senior or nurse on duty. The care staff recorded the room and fridge temperatures daily. The treatment rooms were part of the cleaning schedule. Controlled drugs were stored securely and the key held by an appropriate person. Nursing staff kept accurate records of the stock balance of controlled drugs. The cupboard contained items other than the controlled medicines.

People told us that they felt safe within this residential establishment. One person told us, "I feel very safe in my apartment." One relative with spoke with told us, "Staff are really good, it's safe."

The service had a range of policies and procedures to keep people safe, such as accident, incident, safeguarding and whistleblowing procedures. These were accessible to staff for information and guidance. Staff had an understanding of safeguarding and whistleblowing and knew how to report concerns. One care worker told us, "I would speak to the manager straightaway."

Staff we spoke with had an understanding of safeguarding and whistleblowing in relation to the people living in the home and their vulnerabilities. One staff member told us, "I would always report something if I felt it was not right."

We found the provider kept records relating to disciplinary procedures. We saw evidence of disciplinary hearings with letters to staff members outlining the outcome of the hearing.

The provider had health and safety certificates in place to demonstrate that checks had been completed. For example, electrical installation and gas safety checks.

Inadequate

Is the service effective?

Our findings

The manager provided an up to date training matrix. This confirmed that staff training was not up to date across a range of subjects. For example, learning disability, autism, nutrition and hydration and mental health awareness. This meant we could not be sure that staff had the appropriate knowledge to support people in the service.

People living at Deneside Court had specific clinical care needs and we found not all staff received training in these areas. For example, there were people living at the home who had diabetes. We found that the provider had failed to deliver appropriate training to both nursing and care staff in respect of these areas. We deemed this to be a risk as it was important for all staff supporting people to have a baseline knowledge around people's needs. For example, care staff were supporting people without any knowledge of diabetes. This meant they would not be able to identify the signs and symptoms of someone about to have a diabetic incident, therefore they would not be able to mitigate risks to the individuals in a timely manner.

We also found that when agency nurses worked on the units where people needed PEG feeds no checks had been completed to determine that these staff were competent to provide the feed. The human resources manager told us that the registered provider was aware of this issue and they intended to take steps to ensure all agency staff had the appropriate qualifications and competencies to provide care and treatment for people in the home. We asked that the provider take immediate steps to rectify this to ensure people were being supported by appropriately trained and competent staff.

In addition to this, the permanent staff had not had their competency to PEG feed checked for over two years. The manager told us that the registered provider's policy required competency checks to be completed every three years. We noted on one night we were visiting none of the care staff on the unit were trained to complete PEG feeds and the nurse was overseeing the other unit.

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

We reviewed the supervision plan the manager had developed. The plan indicated staff supervision frequency was bi-monthly. We found that the nurses employed at Deneside Court had not received clinical supervision. Clinical supervision is important so nursing staff have an opportunity to have their skills observed by a competent practitioner and to discuss the support they may need to fulfil their role. Competency certificates for tracheostomy care and peg feeding gave an expiry date; we found several certificates had lapsed. Staff we spoke with felt supervisions were "a bit haphazard at the moment." One staff member told us, "I have had supervision, I told them of my concerns I feel they don't really make an effort." Another said, "I have not had a lot of clinical supervision, I still have not been signed off for care of supra-pubic catheters, but am expected to deliver this care." We found there were no records held regarding agency staff's clinical supervision or competency status. This meant that staff were supporting people with clinical needs without competency checks in place.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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) authorisations.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The care records we reviewed contained limited assessments of the person's capacity to make decisions.

We found that the staff had a limited understanding of the MCA and what actions they would need to take to ensure the home adhered to the code of practice. We found there were no capacity assessments even though evidence suggested some people might lack capacity. Care records did not describe the efforts that had been made to establish that the least restrictive option for people was followed and the ways in which staff had sought to communicate choices to people and were often confusing. We found records could both indicate people had and lacked capacity.

There were no records to confirm that 'best interest' discussions had taken place with the person's family, external health and social work professionals or senior members of staff.

Staff had failed to ascertain the legal status of family members when making decisions for people who used the service. No information was available to determine if relatives had lasting power of care and welfare or had been appointed as a deputy by the Court of Protection. Staff we spoke with were unaware of the restrictions of a person's ability to make decisions for others and the need to have the legal authority to make care and welfare decisions. This meant we could not be sure that the provider was acting within the principles of the MCA.

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

It was unclear as to how many people were subject to a Deprivation of Liberty Safeguard authorisation (DoLS). The care records of nine people, contained conflicting information which both suggested the individual was and was not subject to a DoLS authorisation. When we asked staff who was subject to a DoL authorisation and if anyone had conditions in place, they were unable to tell us and unable to answer.

It was clear from the lack of capacity assessments that consideration had not been given to whether people were being deprived of their liberty. We found that people who staff deemed to have capacity were felt to lack capacity to go outside by themselves so were constantly supervised. No records were in place to show that these people had consented to this level of restriction or that MCA requirements had been followed. We found staff were unaware of the MCA code of practice and the right of people to make representations against their DoLS authorisation.

This was a breach of Regulation 13(5) (Safeguarding people from abuse and improper treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each unit had a communal area for people to sit and watch TV. We found there were not enough seats available if everyone from the unit wanted to sit together. The areas were sparse with very little decoration. No consideration had been taken to make the areas more homely by using tamper proof decoration or safe ornaments.

The provider employed a behaviour team made up of three staff members whom worked three days a week supporting the home. The behaviour therapist told us they have created a training package which forms a part of the mandatory training for staff. This includes positive behaviour support with links to psychology. Staff were required to complete incident forms following episodes of behaviours that challenge, these were given to the behaviour team who reviewed the information. The behaviour therapist explained they met with staff members seven to ten days after the incident to carry out a debrief session where staff were able to discuss what happened in detail. From this session a formulation meeting was held to review plans and behaviours. During the meeting changes could be made to people's support plans. We felt this timescale was long in terms of people whose needs were such that they were a risk to themselves and others. The manager advised this was an organisational process but they intended to have discussions with senior management about this. Another member of the team was an occupational therapist and physiotherapist. They provided individualised therapy sessions in the hydrotherapy pool as well as working with external professionals such as wheelchair services who provided specialist equipment to assist in the mobility of people with complex physical needs.

In discussion with one of the nurses, who was a permanent member of staff, on the first day of the inspection, it was clear they had significant experience to meet the needs of the people currently living in the service. They indicated they had completed recent training on MCA and DoLS along with moving and handling and syringe driver updates.

We spoke to people about meal times and choices available to them. People told us they were given a choice of meals. One person told us, "It's alright, but I go out and eat as well." Another commented, "You can make a drink when you want one." Staff supported people to eat and drink in a respectful manner. We observed people eating together at the breakfast club. This was where people came together to eat and socialise on a morning. People were encouraged to make their own meals as part of their support plans using the facilities on the units.

Staff gave us examples of the various health care professionals involved in people's care. For example, GP's and community nurses. The service kept a diary to indicate when health care professionals were contacted. One relative told us, "They organise the hospital appointments and always let us know what has happened."

Requires Improvement

Is the service caring?

Our findings

Staff told us they would like to do more with people. One staff member told us, "Sometimes I would love to do more with people but it is difficult when you are left alone on a unit and have other jobs to do." We observed one person wanted to leave the unit to go outside, this could not happen as there was no other staff member on the unit to support them.

Staff said, "We do our best to make sure people are cared for but often there is just not enough of us to complete all the tasks." And, "I think its hourly positional changes but couldn't be sure." And, "I would like to say we never miss anything but obviously we do as the records aren't done and to be honest, I couldn't say that we didn't miss positional changes. But I do know we all try our best to make sure people are looked after properly."

We saw that two people required splints applying to their limbs each day in order to reduce the risk of them developing contractures but again records for these were blank. The staff told us it was not their responsibility to put the splints on and the occupational therapist did this when they were in the home. This was not in line with the information in the care plans. The care plans had been written by the occupational therapists and detailed how staff should put the splints in place. We were concerned that the staff were not aware of this need or the impact that could occur if the splints were not applied.

This was a breach of Regulation 12 (Safe care and treatment) and 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives felt the service was caring. One person gave us the 'thumbs up' when we asked about the home. Another told us, "I am looked after, the girls are very good." One relative told us, "It's excellent, we are over the moon with the care." Another told us, "There is a routine here, we have peace of mind." Other comments included, "We cannot fault it here," and, "very pleased with what [family member] gets."

Staff were observed to be caring whilst supporting people in the home. There appeared to be genuine relationships between people and staff. We saw people laughing and appropriate humour being shared between staff and people. When using moving and assisting equipment, staff did so in a dignified manner. People were supported with eating and drinking, staff used prompts at a pace appropriate to them.

Inadequate

Is the service responsive?

Our findings

We found risk assessments and care plan reviews were not up to date. For example, we saw that one person's support plan for skin integrity had not been reviewed in May and June despite being at moderate risk of pressure damage. We found another support plan which was in place to reduce the likelihood of aspiration was not reviewed in June. The associated risk assessment related to choking was dated 10 July 2013. The entry for the July review indicated that the person had increased episodes of gagging and extra salivation. The risk assessment document had not been reviewed to include these findings. This meant that we could not be sure that people were receiving care appropriate to their needs.

We found one person's care record stated their blood glucose should be monitored 'three times a day or as and when'. However the patient recording sheet stated 'twice a day'. This meant that we could not be assured that the person was receiving the appropriate monitoring. Another person's care records indicated they had diabetes. There was no care plan in place for diabetes. The risk assessment for falls did not acknowledge diabetes. This meant we could not be sure that the person was being adequately supported.

We found information in care records for staff to follow if someone reaches 'crisis point'. The plans lacked detail in what to do, other than, 'no more than three staff who must be MAPA trained' this relied on three MAPA trained staff being immediately available. This meant that staff did not have clear person centred instructions of how to support the person if they reached crisis point

The home had put a three-page summary in place for people who used the service but we found this often missed off crucial information such as health conditions, whether people were subject to DoLS authorisations or sections of the Mental Health Act and recent changes in people's health.

We found that the main body of the care records, such as support plans and risk assessments were not personalised. We saw generic templates were used and at times these referred to the person in the wrong gender so we could not be assured they had been created for the specific individual.

From discussion with the registered provider we found they had not considered the adverse impact on people who used the service from inadequate recording of care delivery and lack of oversight of individual care needs.

This was a breach of Regulations 9 (Person-centred care), 12 (Safe care and treatment) and 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Files contained completed hospital assessments. These were documents which would accompany a person with a learning disability if they were admitted or attended hospital to ensure hospital staff had essential information to support the person. We discussed these with nursing and care staff that if a person with behaviours that challenged were to be admitted or to attend hospital as an emergency, staff would accompany them but would not plan to remain. Neither nursing or care staff were aware of any contingency for this. This meant that staff were not aware of the provider's procedure in relation to hospital

admission/attendance.

The service did provide support for people to continue with interests and hobbies. However, relatives and staff told us this does not always happen. One staff member told us, "I understand about the level of staff but we can't meet these needs, we just do the basics." They went on to explain that some people like to go out in the community as part of their recreation and leisure support but cannot always do this because of the staffing levels. One relative told us, "Outings sometimes don't happen if there is no driver, which happens quite a lot. If staff don't know [person] they can't follow the care plan because it's too comprehensive."

We spoke with one staff member and the person they were supporting. The staff member explained some of the activities the person liked to undertake stating that "[person] likes to sing and do portraits and pottery". The person was keen for us to know about their apartment. They told us they were happy in their apartment. They showed us how to make a pottery face. This meant that the person's interest was being acknowledged.

We found evidence in care records to suggest referrals were made to community services when necessary and of visits by health care professionals including dieticians, community psychiatric nurses and advocates.

During our inspection we observed the morning handover, where night staff passed on information to day staff, this contained a good level of detail.

Inadequate

Is the service well-led?

Our findings

The service does not have a registered manager in place. The previous registered manager had recently left the service. The service does have a manager who is new to post (and who had been in post only a couple of weeks at the time of the inspection) who is being supported by the area manager during their induction period. The manager told us they intended to submit an application with the Commission to become the registered manager of Deneside Court, at the time of the inspection a validated application had not been received.

We were informed that the registered provider had systems for monitoring and assessing the service. These systems had not assisted management to identify the cause of poor practice, the gaps in the care practices or the need to make significant improvements. A recent audit of first aid showed recurrent themes with the contents of first aid boxes not being replaced. The fire audit dated June 2016 contained 13 actions however only two were completed in the timescales given on the plan. The service had undergone a weekend service review visit in June 2016, there were several areas where action had not been met and some carried forward from a previous visit with no additional review date.

We found that analysis of safeguarding, accident and incidents were not robust. Records showed that despite incidents occurring lessons learnt were not recorded despite comments about trends and action taken from trends being recorded.

We found a failure in managerial oversight regarding staffing rota. For example, training and competencies of agency staff not adequately scrutinised. Only following our first visit did the registered provider take action to ensure agency staff had the skills and competencies to meet people's needs. But at subsequent visits this remained an issue and agency staff continued to be deployed without having the necessary skills. The registered provider was unaware that they were accountable for the entire practices agency staff completed whilst employed by them.

Also the registered provider failed to have systems in place to ensure staffing levels were appropriate. They used a basic system of number of people to ratio of staff, which did not relate to the actual dependency of people who used the service or placing authority contractual agreements. The registered provider had not reviewed whether people's needs were being met or that staff were working in a safe environment.

The registered provider had not ensured systems were in place to assure themselves that people's needs could actually be met at the home and that people on each unit were compatible. This failure led to people on units being placed at risk of harm, for instance, on one unit people who were living with dementia were residing with people who had complex physical health needs and needed equipment such a PEG feeds. Staff told us that they were unable to monitor the whereabouts of the people and this had led to individuals inadvertently turning equipment off.

The registered provider had not ensured the action plan submitted to the CQC in response the last inspection in March 2016 whereby they confirmed all actions would be completed by 30 June 2016 was fully

met. We found the registered provider had failed to carry out practice and rehearsal sessions for MAPA techniques following team meetings. We found the registered provider's review of staffing levels and training was not maintained by the compliance team as dictated in the action plan. This was a continuation of a breach of Regulation 18 Staffing.

We found the staffing rota contained a weekly on call rota for staff to follow. However when we reviewed the rota for week commencing 31 July 2016, this had not been updated with who was actually on call for that week.

We reviewed minutes of team meetings. There was a recurrent theme through the minutes of both senior staff meeting and staff meetings around the staffing rota and recording by staff. There did not appear to be any documentation to support staffs input in the meetings. The minutes were more of a record of what was said by the chair rather than a record of the actual meeting. This meant it was not clear what staff views and opinions were.

Care records were kept in the nurse's office on each unit which was not always locked. This meant that people's personal care records and information was not stored confidentially. The meant the provider was failing to adhere to data protection requirements. Department of Health Record Management Code of Practice for Health and Social Care 2016.

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

The manager was new to post and was being supported by the area manager. The registered provider was in the process of holding a recruitment drive. The manager told us, "We have recruited new nurses and are waiting for start dates; two are clinical leads, one for each floor.

During the inspection we spoke with the recruitment manager who told us the home was having an open day for people to come in to the home if they were interested in working in care. This meant the registered provider acknowledged the staff shortages.

The area manager told us, "The service does have work to do and we are looking at how to move forward, a clinical trainer has recently been appointed who will work with staff in their development and competency assessments." The manager advised some of the development they are looking at include the allocation of staff using the skill matches of staff to develop working groups. The manager told us, "We are looking at integrating scenarios into the debrief for staff following incidents to help develop skills and knowledge when dealing with behaviours." Other ideas are to include people in the development of the service more by having meetings on each unit. The registered provider had a plan which the area manager and manager updated on a regular basis adding to it on a rolling programme. The manager told us they were committed to making the service better. They told us, "I am confident that we can make the changes to improve the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred.

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made in relation to this breach of Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent No evidence of best interests assessents. Staff did not have clear understanding of MCA and how to apply principles

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made in relation to this breach of Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not safely managed. Staffing levels were not appropriate.

The enforcement action we took:

We imposed conditions on the provider's registration and following an appeals process at the tribunal stage the Court imposed further conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Lack of knowledge in relation to MCA and how this impacts of safeguarding people.

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made in relation to this

breach of Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of effective quality assurance, lack of managerial oversight of the service.

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made in relation to this breach of Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff not appropriately trained, agency nurses training and competencies not checked. Staff competencies not checked regularly.

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made in relation to this breach of Regulation.