Four Winds Care Limited

Admiral Court Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We inspected Admiral Court Care Home on 3, 4, 8 and 15 March 2015. This was an unannounced inspection which meant that staff and provider did not know that we would be visiting. We visited in order to check the actions the provider had taken to improve the home.

We had inspected Admiral Court Care Home in December 2014 and issued a formal warning telling the provider that by 23 February 2015 they must improve the following areas.

- Regulation 13: Management of medicines, as staff were failing to ensure people were protected against the risks associated with the unsafe use and management of medicines.
- Regulation 15: Safety and suitability of premises, as the service was failing to ensure people at its property were protected against the risks associated with unsafe or unsuitable premises.

And by 9 March 2015 they must improve in the following area.

Summary of findings

- Regulation 22: Management of medicines, as the service was failing to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed at the home.

Admiral Court Care home is a large purpose built home registered to provide nursing care. The home has the capacity to take up to 50 residents. Admiral Court is registered to care for older people, people living with mental health disorder and/or dementia as well as people with sensory impairments. At the time of the inspection there were 32 residents living at the home, 16 upstairs and 16 downstairs.

A registered manager had been in place since 1 December 2014, which was the date the home opened under the management of Four Winds Care Limited. 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.

At this inspection we found that there were breaches of all 16 of the regulations relating to care in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These were all of the regulations 9 to 26. Also there were failures to meet the requirements of regulations 11,12 and 18 of the Care Quality Commission (Registration) Regulation 2009. We had serious concerns about the service provided at the home and found that staff failed to meet the needs of the existing 32 people who resided at the home.

We found that the provider had commenced major refurbishment work on the top floor but had taken no action to reduce the impact this had upon people who resided on that floor. They had not moved people to a safer environment whilst the work was completed or put measures in place to ensure people were not living in the area whilst the building work was underway.

We found that the provider had taken no action to address the unsatisfactory elements identified as C2 (Potentially dangerous – Urgent remedial action required) on the electrical installation condition report issued in November 2014. They had failed to address matters raised in the Regulatory Reform (Fire Safety) Order 2005 issued 8 January 2015 or the recommendation made in the Hartlepool Borough Council fire risk assessment dated 23 February 2015.

We found that the provider had not ensured that checks were undertaken to ensure the passenger lift complied with Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Staff and service users continued to use this lift even though they could not be assured that it was safe.

We found that staff had admitted people who because of the design of the home needs could not be met. For instance the home is not registered to accept people with a physical disability but the provider had admitted people with physical disabilities who required adapted wheelchairs into the home and onto the first floor. These are larger than regular wheelchairs. The passenger lift at the home was too small to accommodate these wheelchairs yet we found that people with adapted wheelchairs lived upstairs and the only way up or down from this floor for them was to be carried by staff, which is an unsafe practice. We found that these people had not been able to leave the top floor since admission some months earlier.

We found that the provider had not ensured staff completed fire training and that Personal Emergency Evacuation Plans were in place for all the people residing at the home. Staff initially could not explain how they would safely evacuate people from the home. On 5 March 2015 we asked that the matter was addressed immediately.

We found that the provider did not have adequate systems in place to assess and monitor the quality of the service that was being provided. They had not taken action to ensure they were assured that the building was safe and that satisfactory checks of the building were in place.

We found that care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. Staff had not taken action to ensure people were re-assessed when the facilities in the building were unsuitable for their needs. Staff were unaware of the current people's conditions, needs and their risk profiles and were not able to demonstrate how they meet the needs of the existing people at the home.

Summary of findings

We found that staff were not taking action to minimise presenting risks associated with immobility, choking and poor nutrition/hydration. Staff failed to ensure service users received appropriate medical care for wound care; deterioration in health conditions and the monitoring of potential adverse effects of their medication.

We found that staff had failed to follow the directions of medical professionals and ensure service users were seen by out-patient consultants or that these appointments were made. Staff had not taken action to ensure service users were in receipt of suitable mobility equipment and seating so therefore able to get out of bed.

We found that the provider did not operate effective recruitment procedures and evidence was not available to show that people had the appropriate qualifications, skills and experience for the role. There were not sufficient numbers of suitably qualified, skilled and experienced people employed to provide the care that people required. Staff had not received appropriate professional development and had not been suitably trained.

We found that people were not protected against the risks associated with medicines because the provider had not ensured appropriate arrangements were in place to manage medicines. Neither were people protected from the risks of inadequate nutrition and dehydration.

We saw that the provider did not have adequate systems in place to protect service users from abuse caused by acts of omission and neglect. Staff did not ensure suitable arrangements were in place to protect service users against the inappropriate use of physical intervention.

Where people did not have the capacity to consent the provider had not ensured that staff acted in accordance with legal requirements.

We found that agency nurses who worked at the home were not provided with suitable or detailed information about the people's conditions, primary needs and current nursing needs. We also found that people were not protected against the risks of unsafe or inappropriate care because the care records were not accurate.

We found that the ambient temperatures within the home were in excess of 25°c and the provider had taken no action to ensure this did not adversely impact the wellbeing of the people who used the home. There were no effective systems in place to ensure that adequate cleaning and infection control prevention were maintained.

We found there were multiple of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have judged these findings to have a major impact. This is being followed up and we will report on our action when it is complete. You can see a summary of the actions we have asked the provider to take, which you can see at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe

We found that people who used the service and others had not been safe.

Staff had not met people's needs or ensured risks to people from the environment were reduced or minimised.

There were insufficient suitably qualified and experienced staff employed to meet people's needs. Recruitment procedures were in place and but appropriate checks were not undertaken before staff started work.

Medication was not handled, stored and administered appropriately.

Inadequate

Is the service effective?
We found the service was ineffective.

Staff had not received support from the provider to ensure they had the skills, knowledge and experience to provide care to the meet the needs of the people who used the service.

The requirements of the Mental Capacity Act 2005 and the Mental Health Act 1983 (amended 2007) were not met. Some people's lifestyles were restricted unacceptably and without due regard to their rights.

The catering staff were not appropriately trained and staff did not ensure people received a healthy balanced diet and adequate amounts of fluids.

Inadequate

Is the service caring?
We found the service was not caring.

Staff were very caring but lacked the skills and knowledge needed to ensure they developed therapeutic relationships.

The service was not designed in a way that would promote people's independence and autonomy.

Inadequate

Is the service responsive?
The service was not responsive.

People did not receive personalised care that was responsive to their needs.

People were not engaged in any meaningful activities and staff appeared to feel their role was to observe people from doorways and nursing stations.

When people raised concerns, staff did not recognise them as complaints or identify allegations of abuse so did not pass to the appropriate authorities.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The provider did not monitor or assess the service and had not ensured that people who used the service were safe, received effective, caring and responsive services which met their needs.

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

A limited number of visitors views had been sought about the home in February 2015 but not before. Staff were observed to disregard any views expressed by the people who used the service.

Admiral Court Care 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 3, 4, 8 and 15 March 2015 and was unannounced.

The inspection team consisted of four staff on each visit and this was a combination of inspectors and inspection managers.

Before our inspection, we reviewed the information we held about the home and contacted the Clinical Commission Group (CCG) to obtain their views after their recent audit.

Over the course of the four days the team observed the care being provided throughout the home; spoke with the regional manager, registered manager, a manager who was working at the home but employed at Highnam Hall , the administrator, the quality manager, five nurses, 15 care staff, the cook, two kitchen assistants and a domestic staff member. We also reviewed ten sets of care records, the medication and staff records as well as management information such as infection control audits.

Inadequate

Is the service safe?

Our findings

During the inspection of Admiral Court we identified significant concerns with the service. In December 2014 we had issued a formal warning in respect of the maintenance of the building; administration of medication; and employed of sufficient suitably qualified and experience staff. The provider sent us information to show how they were addressing these issues and assured us they would be compliant by February 2015.

At this inspection we found the provider had failed to achieve compliance with any of these regulations.

We found that the provider had commenced major refurbishment work on the top floor but had taken no action to reduce the impact this had upon people who resided on that floor. They had not moved people to a safer environment whilst the work was completed or put measures in place to ensure people were not living in the area whilst the building work was underway.

Contractors had been knocking out walls; taking rubble out and generally reconstructing the interior of the top floor. People who used the service has been expected to continue to live in this environment and staff took no action to reduce their exposure to dust, debris or access to equipment such as electrical drills or to reduce tripping hazards. We saw a socket with exposed electrical wires on the corridor where people who used the service were walking by this socket. We were aware that the local commissioners had raised this matter the previous day. No action had been taken we stood and waited until the maintenance person covered the exposed wires with a light switch cover.

We found that the provider had taken no action to address the unsatisfactory elements identified as C2 (Potentially dangerous – Urgent remedial action required) on the electrical installation condition report issued in November 2014. They had failed to address matters raised in the Regulatory Reform (Fire Safety) Order 2005 issued 8 January 2015 or the recommendation made in the Hartlepool Borough Council fire risk assessment dated 23 February 2015.

This was a continued breach of Regulations 15 (Safety and suitability of the premises); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found medicines practices remained unsafe and continued to be managed in the same way as reported on in December 2014.

The system for obtaining, handling and administering medicines was so disorganised and chaotic that we found a number of people had not received their medicine. We observed the clinical lead nearly administer the incorrect medicine to one person. We also saw that medicines were being covertly administered (hidden in foods so the person would not know) without any authorisation being sought to do this from the multi-disciplinary team. We found where health care professionals issued prescriptions these were not sent away and collected in a timely manner so people had gone without medicine such as antibiotics for a number of days.

Medicines were not managed safely for people and records had not been completed correctly. Medicines were not obtained, administered and recorded properly.

This was a continued breach of Regulations 13 (Management of medicines); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found levels of competent staff being employed at Admiral Court remained unsafe. We found that the registered manager was working as a nurse and providing the clinical leadership. None of the actions they had taken in this role of clinical lead had led to any improvements in the care and treatment being provided. The other manager was not a nurse but was writing the care plans for nursing clients, which related to their mental health disorders. We found a number of these plans were inappropriate and failed to appropriately support people with their mental health needs.

Since the last inspection we found that two nurses had been employed but bank and agency nurses provided cover on every day the team visited. We found that one nurse and three care staff provided cover on each floor and additional care staff were in place to provide one-to-one support for three service users. However the evacuation plan submitted the provider gave us on 5 March 2015 stipulated that in the event of a fire two staff would support each immobile service users. We noted that ten staff would be needed to undertake this task and the registered manager, one care staff member and three ancillary staff would be required to support the remaining 27 service users, some of whom had limited mobility.

Inadequate

Is the service safe?

On 8 March 2015 we saw that a newly refurbished locked eight place unit had been opened. This was designed to accommodate service users who displayed behaviours that challenged and could be violent. We saw that the provider had taken the decision not to increase staffing levels on this floor and one member of staff worked in the eight place unit. The staff member working on this unit told us that they did not have a portable alarm. To summon help they would need to rely on accessing a nurse alarm in the bedrooms and wait for staff to respond. They were not confident that the other staff would respond in a timely manner. The other staff on the upstairs unit did not consider the single staff member would be at an increased risk and told us they would try to respond but the staff member would have to wait if they were busy.

We noted that people's files showed they were displaying a range of current and significant risks such as violence, expressions of suicidal intention, poor gag reflex with a high risk of choking and extremely restricted movement. Staff who were working in the home had limited understanding of what these risks meant for their practice or how to use the information in assessments. We found that the care staff had not been provided with any support to develop the skills needed to complete appropriate risk assessments around these types of behaviour.

This was a continued breach of Regulations 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's statement of purpose and service user guide stated that the home was suitable for people who had lived with mental health disorders; dementia; and/or sensory impairments. However the staff had admitted people with significant physical disabilities. The design of the home was not compliant with that expected for service for people with physical disabilities so the corridors and doorframes were too narrow; the largest bedrooms were 12m^2; and the passenger lift was too small to accommodate adapted wheelchairs.

This was not only a breach of Regulations 15 (Safety and suitability of the premises); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that the provider had failed to request to amend the service user bands so that they could accommodate people with physical disability or a learning disability. Staff had admitted these groups of individuals without this being agreed by CQC. The Statement of Purpose had not been changed to reflect the alteration to the admission criteria, in addition an amended version had not been sent to us. These are failures to meet the requirements of regulations 11 and 12 of the Care Quality Commission (Registration) Regulation 2009.

Over the course of 3, 4 and 8 March 2015 we observed how ten people's care was delivered and reviewed the care records for these people. We found that these people had complex nursing care needs however none of the records provided an appropriate assessment of their needs. None of the staff we spoke with could clearly detail when these people were admitted to the home; what care needs they had; their current condition and how they were to be supported. We found that staff failed to ensure people's needs were assessed and care was planned and delivered in ways that would ensure service users were protected from inappropriate or unsafe care.

This was a breach of Regulation 9 (Care and welfare); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the registered manager had not notified the safeguarding team and us of a number of incidents, which were safeguarding matters.

This is a failure to meet the requirements of regulations 18 of the Care Quality Commission (Registration) Regulation 2009.

We found that both the registered manager and other manager failed to recognise when incidents or allegations would be considered to be abuse and therefore need referring to the local safeguarding team. We found that staff had not received meaningful safeguarding training and did not know who in the management team to approach. The staff also did not know they could raise safeguarding alerts.

There had been occasions when the police should have been called but were not for instance when allegations of theft were made or people had displayed challenging behaviour. Neither had these been reported to the LA safeguarding team or us.

People told us they felt frightened of staff. Staff confirmed that they had also been told this, as did the registered manager but they had not recognised this as a safeguarding concern. When we raised this with the manager from the other home they dismissed it as a part of

the individual's mental health condition. Nothing in these people's care records suggested that they had mental health conditions that would lead to them making false allegations. Therefore no action had been taken to report the matter; investigate the concerns; or mitigate the risk.

We raised a number of safeguarding alerts with the local authority during the inspection.

The high temperatures in the home were a concern. During the visit the temperatures remained excessive and at least 25°c throughout the first two days. We asked that action was taken immediately to address this matter but found on 8 March 2015 they were still in excess of 24°c. Prior to us raising the matter no action had been taken to routinely monitor the temperature on the top floor or to ensure action was taken when they became excessive. Although air con was provided these were portable units and during our visit staff never turned them on.

We saw that in communal areas no jugs of water and so forth were available so no-one had access to drinks unless staff provided it. Throughout the visit the only drinks made available were at the discretion of the staff. Staff were not monitoring temperatures to make sure people were not at risk of dehydrating nor were they taking action to make sure people did not overheat or dehydrate. This is an act of omission and therefore a form of abuse.

This was a breach of Regulation 11 (Safeguarding service users from abuse); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A risk assessment of the building in terms of ensuring the safety of the staff and others had not been developed. Until the beginning of February 2015 when the registered manager from Highnam Hall had commenced overseeing the operation of Admiral Court Care Home no action had been taken to obtain any of the maintenance certificates. All of these maintenance certificates were out of date and albeit some had been renewed others such as Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) were out of date. We found that the provider had not put measures in place to ensure checks were carried out in a timely manner.

We also found that the provider had not ensured that checks were undertaken to ensure the passenger lift was safe. Staff and service users continued to use this lift even though they could not be assured that it was safe.

On 3 March 2015 we found that the nurse call alarms in some bedrooms were not located in a position that was accessible for the people or were not in place. One person reported that their nurse call alarm was unreachable, as it was at the opposite side of the bedroom. We confirmed this was the case. We discussed the matter with the registered manager who reported that they had not noticed this before but had made no undertaking to ensure nurse call alarms were accessible. On the 8 March 2015 we saw that the call alarms remained either inaccessible or unavailable in service users' bedrooms. We raised this concern with the regional manager who undertook to ensure all call alarms were accessible. On 15 March 2015 we saw that most call alarms were accessible but those for the some were not in place. For the people who did not have access to nurse call alarms no other means of raising the alarm were accessible such as pressure mats and they were unable to call for help.

This was a breach of Regulation 16 (Safety, availability and suitability of equipment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the records of all of the staff to check that the home's recruitment procedure was effective and safe. We found that 35 staff did not have either a Criminal Records Bureau (CRB) check or Disclosure and Barring Service clearance (DBS). DBS checks show whether people have been convicted of an offence or barred from working with vulnerable adults. The registered manager and administrative staff confirmed not all staff had a DBS check. In the December 2014 inspection it was identified that none of the staff employed at the home had CRB/DBS clearance checks and at that time the provider provided assurance that these would be obtained. We found that since then the provider had obtained only four DBS clearance checks for existing staff and none for the staff the provider had recently employed.

We found that over the course of the inspection staff who did not have a valid CRB/DBS check were working unsupervised at Admiral Court Care Home. Two of the newly recruited staff told us that as a part of their induction they had been tasked with providing the one-to-one support for a people. The people identified as requiring one-to-one support were the most vulnerable people residing in the home and were often prone to presenting with behaviours that challenge. We heard that these newly

Inadequate

Is the service safe?

appointed staff undertook this one-to-one support on the first day of work at the home. These staff did not have valid DBS checks and had not received training around how to work safely with these people.

We checked all of the staff records for the nurses. We identified that staff had not obtained information for five of the nurses currently employed at Admiral Court Care Home to confirm that they had current Nursing and Midwifery Council (NMC) registrations. We asked the registered manager for the nurses NMC PIN numbers but neither they nor administrative staff could provide this information. The registered manager confirmed they had not checked the NMC website to confirm the nurses maintained current nursing registrations.

This was a breach of Regulation 21 (Requirements relating to workers); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked around all areas of the home. We found that the home was of a poor standard of cleanliness. The corridor, bathroom and communal area flooring was extremely dirty, bedroom carpets were stained, the bathrooms and toilets were dirty, with stains. Two bathrooms had what looked like excrement along the bath hoists and one bath had the remnants of what looked like excrement along the base.

We saw that woodwork was exposed in bathrooms and the washable flooring was coming away from the walls, which meant the flooring could be harboring infections. We found that the home remained as seen during the December 2014 inspection report.

We requested to see the deep clean rotas from January 2015 as well as infection control audit and action plans for previous six months. The staff could not produce this information. The registered manager, manager from Highnam Hall, the administrator, and the quality manager confirmed that deep clean rota's and infection control audits had not been completed. We requested to see hand washing audits and information about who the infection control champion was at the home. We confirmed that this information was not available and the manager from another home believed that the person designated as the infection control champion had not been doing this role for some months.

This was a breach of Regulation 12 (Cleanliness and infection control), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said, "I hate it here." "Most of the staff are good but I would prefer to live elsewhere." And "Its ok I suppose."

Inadequate

Is the service effective?

Our findings

The clinical lead told us they had been in post seven weeks and was a registered nurse for people with learning disabilities. They could not confirm what additional training or action they had taken to ensure they were competent to work with people with mental health and physical health needs. The manager from Highnam Hall confirmed that none of the permanent nursing staff had received mandatory training and they had not been assessed.

There was no evidence to show that the provider had checked if the agency nurse had the competencies required for working with service users at Admiral Court Care Home. The inspection team found that the nursing staff lacked the skills and competencies to ensure people safely received the care they needed.

We found that the agency nurse on duty on 8 March 2015 was completing their second shift at the home. In discussions with us the nurse confirmed that they were unfamiliar with people's needs and had to rely on care staff to tell them what people needed. The registered manager could not provide the inspection team with any evidence to show that the provider had taken action to check that the agency staff had the necessary competencies to provide the care and treatment the people at the home needed.

This was a continued breach of Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We requested a copy of the home's training matrix. The matrix contained significant gaps in all identified training needs. For example, the matrix indicated that 10 of 61 staff had completed food hygiene, 16 of the 61 moving and handling training. He found that it was apparent from discussions with staff, the matrix and available records that staff had not received mandatory training, competency assessments or training around how to work with the client group.

We found that despite raising matters on 3, 4 and 8 March 2015 with the registered manager and manager from another home, action was not taken to ensure staff received access to immediate training on the fire procedures. Despite discussing the inappropriateness of new staff completing one-to-one work on 3 March 2015 with the registered manager. On 15 March 2015 staff on their first day working at the home provided the one-to-one support for people who could present with challenging behaviour.

This was a breach of Regulation 23 (Supporting workers), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that there was insufficient communal space of the top floor to provide room to accommodate enough comfortable seating and dining room furniture for the 16 people residing on this floor. Due to the lack of furniture at least three people needed to eat in and sit in their bedrooms during the day. On the ground floor we found that the bathing facilities did not meet the needs of the people. Three domestic style baths were provided, two of which had bath hoists but these were only suitable for people who had flexibility in their joints and could bend their legs.

We found that no equipment such as adapted wheelchairs or seating had been requested for these people who had become physically disabled whilst in the home. Also staff did not have access to appropriate moving and handling equipment such as slide sheets or hoists that would support people whose limbs were deformed by contractures and were rigid. The staff we spoke with could not outline how they would support these people to mobilise.

This was a breach of Regulation 16 (Safety, availability and suitability of equipment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff did not understand the requirements of the Mental Capacity Act 2005 and had not fully introduced either the principles or the appropriate documentation into the home. We found that staff believed that a number of the service users lacked capacity to make decisions and other service users had full capacity. From our review of the care records they found that staff had incorrectly assessed service user's capacity. We found that staff had assessed people as having capacity to make decisions and then sent a referral for Deprivation of Liberty Safeguard (DoLS) authorisation. This contravenes the DoLS code of practice.

We found that people who had been assessed as lacking capacity had been asked to sign care plan documentation. Also staff had failed to ascertain the legal status of family members when making decisions for service users. 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 they spoke with were unaware of the restrictions on a person's ability to make decisions for others and the need to have the legal authority to make care and welfare decisions.

We saw in care records do not to attempt cardio pulmonary resuscitation (DNACPR) documents. For one person we found that a capacity assessment had been completed by the clinical lead in relation to a decision. We saw that they had not included any other parties in the decision making process. We noted that one person did not have contact with their next of kin but the clinical lead had not sought the input of an independent mental capacity assessor prior to requesting a DNACPR. Making this type of life changing decision in this manner contravenes the requirements of the Mental Capacity Act 2005 and associated code of practice.

We found that the actions of staff contravened the requirements of the Mental Capacity Act.

This was a breach of Regulation 18 (consent), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that many areas of the home were not Disability Discrimination Act compliant both in terms of meeting the needs of people with a physical disability and the needs of people living with a dementia. The dementia care units had not been developed to make the units dementia friendly so were not decorated in ways that enhanced people's level of independence and supported them to find their way around and to their own room.

People on the top floor units were segregated by a keypad door. This reduced the overall available space for people to use and made the residential unit very small. No explanation could be provided for this practice but it meant that on the residential unit the dining area was an enclosed box with no windows and only one lounge was available.

The dementia care nursing services were not decorated in ways that enhanced people's level of independence and supported them to find their way around and to their own room. Recognised guidance had not been followed in respect of creating a dementia friendly environment such as how to use colour and material to make it easier for people to make their own way around a unit, find toilets and find meaningful occupation.

This was a breach of Regulation 17 (1) and (2) (Respecting and involving service users), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at whether people who used the service were receiving adequate nutrition and hydration. On 3 and 4 March 2015 we found that the fluid intake charts staff completed suggested that service users who were at risk of dehydration were receiving less that than the recommended volume of fluid per day.

We reviewed three people's fluid balance charts. We saw for one person staff had recorded on 27 February 2015 they had 850mls of fluids; on 28 February 2015 they received 600mls of fluid; on 1 March 2015 they received 800mls of fluid and on 2 March 2015 they received 800mls of fluid. We saw in another person's that on 27 February 2015 they had 800mls of fluids; on 28 February 2015 they received 200mls of fluid; on 1 March 2015 they were offered but received no fluids; on 2 March 2015 they received 500mls of fluid. We also saw that another person on 27 February 2015 they had 1050mls of fluids; on 28 February 2015 they received 780mls of fluid; on 1 March 2015 they received 1000mls of fluids; on 2 March 2015 they received 500mls of fluid.

We observed staff supporting service users in the communal area and saw that they offered drinks at 8.30am, 11.15am, 12.30pm and 3.45pm. We also regularly checked whether people who were bedridden had drinks. We saw for one person that their jug of juice never altered and beaker remained dry and in the same position. On 4 March 2015 we repeated the same observations and saw that the staff practices remained the same. We found that the provider failed to ensure that service users were protected from the risks of dehydration.

We found from discussions with staff that two people had compromised gag reflex. We saw that care staff were delegated to assist them to eat. In discussions with these staff we found they had not had training around how to assist people with poor gag reflex to eat or how to identify if people with this condition were choking. We found that the arrangements in the home failed to ensure people safely received suitable and adequate nutrition or hydration.

We spoke with the cook who told us that none of the catering staff held current basic food hygiene level two certificates. This qualification is required for all staff handling raw food products. The cook also confirmed that

none of the catering staff had attended any training around meeting the nutritional needs of older people. We reviewed the training records and confirmed that catering staff had not attended this type of training.

This was a breach of Regulation 14 (1) (Meeting nutritional needs), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said, “The girls try their best.” And, “Most of the staff are pleasant and do help you”. And, “The meals are fine and we are all well fed.”

Inadequate

Is the service caring?

Our findings

We reviewed ten people's care records and found that these were inaccurate and incomplete. We found they were not written in a person-centred manner and some were extremely judgemental about the person. They referred to people as if it was fault or due to their condition that they expressed dissatisfaction with the home rather than encouraging staff to explore why someone might be upset. We found that staff treated people with concerns with contempt and wrote care plans around safeguarding the staff rather than the people who used the service.

We found that the nurses and care staff on duty during the four days could not outline what people's care needs were. The nurses were unable to detail where people had pressure ulcers, how many each person had or what treatment they were to receive. Care staff could not detailed the care and support staff needed to provide and in one instance were unaware that one person had sustained a fracture. We found the information in care records was extremely limited. No overarching assessment documents were contained in the record and there was no admission assessment document. The previous provider documents were in place for some people's care but this was out of date.

We found that along the corridors service user records were left lying along handrails and walls. In the dining rooms they were left lying unattended on tables. None of the nurses offices were secure and care records were stored on open-fronted shelves. We found that the provider failed to ensure the records were securely stored.

This was a breach of Regulations 9 (Care and welfare) and 20 (Records), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On 3 March 2015 we observed staff attend to people's personal hygiene needs and change dressings whilst the bedroom doors were open. We found this compromised people who used the service dignity.

Throughout the four days of the inspection the team saw that no therapeutic activities took place. Predominantly people sat in armchairs whilst the television played in the background. We saw staff responded to peoples' requests if they were awake, however, there was no proactive interventions from staff. The National Institute for Care Excellence (NICE) 'Dementia Supporting service users with dementia and their carers' in health and social care 2006 states:-

'For service users with all types and severities of dementia who have comorbid agitation, consideration should be given to providing access to interventions tailored to the person's preferences, skills and abilities. Because service users may respond better to one treatment than another, the response to each modality should be monitored and the care plan adapted accordingly. Approaches that may be considered, depending on availability, include: aromatherapy, multisensory stimulation, therapeutic use of music and/or dancing and animal-assisted therapy'. These guidelines also state under 'Managing risk' 'Health and social care staff who care for service users with dementia should identify, monitor and address environmental, physical health and psychosocial factors that may increase the likelihood of behaviour that challenges, especially violence and aggression, and the risk of harm to self or others. These factors include lack of activities'.

We saw staff almost acting as 'guards'. The staff tended to stand at doorways to the lounges or sit in the offices with large observation windows rather than sitting and speaking with people. We found that the staff failed to pay due regard to peoples' human rights and actively support them to be involved in their care and treatment.

It was also unclear why some people resided in the home as they had a physical disability and the home is not registered or suitable to support people with this condition. For instance a person with physical disabilities had been admitted to the top floor even though their wheelchair would not fit into the passenger lift. The staff and people who used the service, who were able to comment, did not know what the aim of the service was or how they were to be supported.

This was a breach of Regulations 17 (1) and (2) (Respecting and involving service users), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service responsive?

Our findings

We found that care records were inaccurate and incomplete. We could not establish why people had been admitted to the home. The care records did not detail people's needs, whether people were subject to any legal constraints such as sections of the Mental Health Act or how they were supported. We found that the assessment documents and care records gave no detail about the goals they were working towards.

This was a breach of Regulations 9 (Care and welfare) and 20 (Records), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that none of care files contained documents designed to improve the transfer of information about individuals should they require admission to hospital. We found that there were no summary assessment documents in people's care records to detail their past medical history, current physical and mental health needs, their current care needs, information about advanced decisions, end of life care wishes or where people presented with challenging behavior how these were displayed by the individuals or positive interventions that could be used to reassure people throughout their transfer. Without this information medical staff at the receiving hospital would be hindered in their ability to treat the service user appropriately and in a timely manner.

We saw in people who used the service care records that consultants had requested referrals to be made to out-patient clinics that staff needed to follow up. However we could find no information to show if these had been followed up. Also we saw that people had been diagnosed with other healthcare conditions such as cancer but the new diagnosis were not written in any of the individual care records. None of the staff we spoke with were aware of this information so could not give us assurance that people were being seen by other health care professionals.

We found that the staff had not ensured people were supported to see other healthcare professionals. We noted a wide range of instances in care records that indicated people were supposed to be referred to consultants or other healthcare professional. From discussions with registered manager and the other manager we found this had not happened. Even with us prompting the staff that these actions needed to be taken the following week when we visited we found that no action had been taken.

This was a breach of Regulation 24 (2) (Cooperating with other providers), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Families we spoke with told us that, although their relative wanted them to be fully involved in their treatment and act as their representative, they had not been routinely involved in reviews or relatives meetings. One relative told us they had only recently been told about a review after it had occurred and then been informed that at this review a DNACPR had been agreed. They had been distressed by this as they were unaware that their relative was perceived as being so ill.

The complaints procedure was inaccurate and gave no detail about how to identify when others needed to be notified such as the police and how, if appropriate, staff were to thoroughly investigate the concerns. The policy was inaccurate as it told people to make complaints to us if they were not happy with the complaint investigation completed by the provider.

We witnessed people raising concerns about the provision in Admiral Court Care Home but saw that staff, registered manager and the other manager did not treat these as complaints; support people to raise them formally; or discuss them with the registered manager. People told us that they had made complaints, which staff confirmed had been the case. When we reviewed the complaints file we saw that these complaints had never been recorded and therefore it could not be confirmed that this matter had been investigated.

In the complaints file we saw only one complaint had been recorded in the file since the provider had taken over the operation of Admiral Court Care Home. We saw this complaint related to a person's clothes and personal effects going missing. We found that the manager from Highnam Hall had investigated the complaint but had not taken appropriate steps to alert the police or local safeguarding team to a potential theft.

This was a breach of Regulation 19 (2) (Complaints), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service responsive?

People said, “Some of the staff listen to you but others aren’t bothered.” And, “Often they say I have said I don’t want to get up when I do so no one comes to give me a hand”. And, “I do like the staff and think they are being helpful.”

Inadequate

Is the service well-led?

Our findings

The provider on taking over the registration of Admiral Court had been aware that none of the recruitment and training information was available. However they had taken no steps to address these shortfalls or to ensure staff were competent and equipped to meet the needs of the individuals admitted. They had not reviewed staffing levels to make sure there were sufficient staff in post to meet the needs of people or to ensure people remained safe when the major refurbishment work was undertaken.

This was a breach of Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager and manager from Highnam Hall told us that they were unaware of the systems in place for overseeing the home. These staff told us that they had developed some systems for monitoring and assessing the effectiveness of the home. We found that the processes the home had for assessing and monitoring the quality of the service provided to people was limited and many of the audit documents were not in place. Staff produced recruitment and training matrix that highlighted many gaps but told us they had yet to develop action plans to detail how to address the issues. We found that the system for monitoring the performance of the home could not be confirmed as effective.

Staff could not provide any records that would show how the provider monitored the nursing service and ensured all aspects of practice were effective and adhered to clinical guidelines. The registered manager and manager from Highnam Hall could provide no evidence to show how the provider monitored the competency of the nursing staff or the quality of the nursing care being delivered.

The provider is required to complete a review called a regulation 10 visit and report. No evidence was available to show that the provider completed these reviews or ensured the service operated effectively and risks were managed.

As shown throughout this report we identified that there were significant deficits in the performance of the home and skills of the staff. The provider did not have systems in place to ensure these were identified by their staff.

Staff were unclear about what actions the registered manager was taking to review the home and felt they were not approachable or supportive. We heard from some staff that they did not know who the registered manager was and thought this might be the manager from Highnam Hall or the administrator. Staff had no understanding of the evident gaps in practice, the problems with the home or the improvements the provider intended to make to the home.

This was a breach of Regulations 10 (Assessing and monitoring the quality of the service provision) and 20 (1) (Records), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider failed to take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not always protected against the risks associated with medicines because the provider failed to have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken steps to ensure people were assessed and appropriately placed at the home. The provider had not taken steps to ensure that staff were able to meet people's needs; or that any risks of serious harm were minimized. Staff failed to plan and deliver care in line with people's needs and ensure they received treatment.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who use services and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People were not safeguarded; or protected from the risk associated with excessive heat; or those related to the use of physical intervention.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The provider failed to ensure that staff maintained appropriate standards of cleanliness and hygiene and protected people from the risks of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The provider had not made appropriate arrangements for people at Admiral Court Care Home were supported to receive this nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

This section is primarily information for the provider

Enforcement actions

People who use services were not provided with suitable equipment and sufficient quantities of equipment to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who used the service were not respected. Staff did not encourage people to lead independent lifestyles. The home had not been designed to ensure people living with a dementia and those with a physical disability were supported to remain independent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider failed to ensure staff adhered to the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The provider failed to ensure people were supported to raise complaints or that when they did these were thoroughly investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider failed to ensure accurate records were maintained in respect of each person using the service and the management of the home.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider failed to ensure staff had the necessary qualifications, skills and experience which are necessary for the work to be performed and were fit to work at the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider failed to ensure the staff were supported and trained to meet the needs of the people who used the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers **The provider failed to make suitable arrangement to protect the health, safety and welfare of the people who use the service by working in collaboration with others.**