Four Seasons (Bamford) Limited

Priory Park Care Home

Inspection report

Priory Crescent
Penwortham
Preston
Lancashire
PR1 0AL

Tel: 01772742248

Date of inspection visit:
25 October 2017
30 October 2017
02 November 2017
08 November 2017

Date of publication:
05 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on the 25 and 30 October and 2 and 8 November 2017. The first day of the inspection was unannounced which meant the provider was not expecting us on the date of the inspection.

Priory Park Care Home is located in the Penwortham area to the outskirts of Preston. The home provides support for up to 40 people with either nursing or residential care needs. At the time of the inspection there were 38 people living in the home.
The ground floor of the building was non-residential and was primarily an office area. The home's hairdressing salon, laundry and kitchen facilities were also on the ground floor.

There was a lift to both the first floor, where people were supported with nursing needs and to the second floor, where people were living with residential needs.

The home was last inspected in October 2016 where one breach to the regulations was found for a failure to notify the CQC in the event of other incidents. These included allegations of abuse, serious injuries and any police incidents. We made recommendations at the last inspection for the home to ensure appropriate recruitment practices were followed and to ensure appropriate consent was gathered. We found on-going concerns in the two areas where we had previously made a recommendation. For this reason the provider has been found in breach of the associated regulations. We also found incidents that should have been reported to the commission at this inspection, as at the previous inspection, which has resulted in an on-going breach.

The provider forwarded the commission an action plan following the last inspection which we referred to as part of this inspection.The provider had a registered manager who was based at the home. 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.

When we arrived on site to conduct the inspection we found the home was partly being refurbished and redecorated. As a consequence on the first day of the inspection we conducted mainly reviews of paperwork and returned a week later to complete our observations. We returned to provide feedback and gather any additional information required when the registered manager returned from leave.

During this inspection we found the home was staffed by different job roles and different numbers of staff on most days. This may have compounded on the number of concerns found. We have made four recommendations throughout the report to address the concerns with the staff team.

We found records used to manage the day to day delivery of the service were not consistent and in some

cases were inaccurate. Contemporaneous records are important to enable the home to evidence they are aware of the service required and can evidence the required service is being delivered. We have found a breach in this regulation.

We had concerns around the care files for the people living in the home. This included information held in them about how peoples' needs and associated risks were assessed and how the records were used to show person centred care was being delivered that met peoples' assessed needs. We have made two breaches to the regulations around risk assessment and person centred care.

We have also noted a breach about how the home was delivering support to people who were at risk of receiving inadequate nutrition and hydration. We found assessments were not consistent and action required to support people in this regard was not always taken.

We had concerns about how the home was managed. We found the home did not have a comprehensive quality audit and assurance system. We found audits were not completed as required and feedback received was not acted upon in a timely way. We have made two breaches to the regulation under well-led around good governance.

We have also made 16 recommendations including the four noted above for staffing. These are made when the providers need to take additional steps to ensure regulations are not breached moving forward.

We have made recommendations around consistency of the implementation of the MCA, ensuring actions are undertaken as identified within audits and action plans and formalising systems and procedures to ensure safe and effective care and support is delivered.

We found staff at the home were friendly and worked well together. There was a number of new staff due to join the team which should, following suitable induction allow for better service delivery.

We found the home had complete and accurate records around the options of people at the end of their life.

We found the home sought the support of other professional teams when they assessed people needed more specialists support.

Staff described good on line training and told us they had completed both mandatory and requested additional training to better meet people's needs.

We found the provider ensured all the equipment at the home and systems used to keep the home safe were regularly tested by suitable professionals.

The staff at the home administered and recorded medicines safely and in a dignified manner. Person centred care plans supported staff with the information they needed to do so.

The home had comprehensive hospital passports, ready for final completion in the event someone was admitted to hospital in an emergency. These included details around medication and the risks and needs associated with the person's health.

The provider took immediate advice and redecorated the upper floor immediately upon concerns being raised.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

A business continuity and contingency plan had been developed and risk assessments to support this were completed upon request. Personal Emergency Evacuation Plans (PEEPs) were not up to date and did not reflect people's current needs

Over the course of the inspection we did not see consistent staffing levels. When we reviewed how the provider agreed suitable staff were in place, procedures had not been effectively followed.

The home's recruitment procedures were not consistently followed.

Risk assessments were not consistent with people's needs and risk management plans had not been routinely developed.

Medication systems were generally effective at meeting people's needs. Care plans had been developed including protocols for the administration of as and when medication.

Is the service effective?

Requires Improvement

The service was not always effective.

We saw systems were in place to support people with their nutrition and hydration but these were not consistently implemented. Some people were losing weight and they were not in receipt of the required support.

Some consent had been collated but it was not clear if those consenting for treatment on behalf of people had the authority to do so. However, the MCA was considered with assessments and best interest decisions routinely taking place and outcomes being recorded.

There was a good suite of mandatory training but practical training in moving and handling had expired for approximately

half of the staff.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw staff treated people with dignity and knocked on peoples' doors before entering their rooms.

We found communal toiletries were being used when people did not have their own and some of the bedding and towels in use at the home were of a very poor standard.

People told us they were not involved with developing or reviewing their care plans, but we could see from the plans that people's views were incorporated into them.

We were told and saw the food served did not meet everyone's requirements. We saw a vegetarian went without a hot meal on both lunch time sittings as a vegetarian option was not available.

Is the service responsive?

Requires Improvement

The service was not always responsive.

At the time of the inspection there was not enough going on. We were told a new activity coordinator had just been recruited.

We found peoples' needs were not always correctly assessed and staff were not aware of the care and support everybody needed. We saw some good examples of staff who knew the people living in the home well but this was not necessarily based on their assessed needs.

The home had a complaints procedure which was accessible to people in the home but no formal complaints had been made since the last inspection.

Is the service well-led?

Inadequate

The service was not well-led

We found there was a limited system of quality audit in use at the time of the inspection. This made improvement planning difficult to measure.

The provider had a comprehensive set of policies and procedures but many of them required updating in line with new regulations and best practice guidelines.

There was some evidence of people in the home being involved with how the home was managed and run but this was not routinely developed into actions that have been taken forward.

There was a lack of environmental risk assessments at the time of the inspection the provider did develop those in relation to emergency planning before the close of the inspection.

Where concerns had been noted action was not taken to reduce risks.

The provider was not sending all the required notifications to the commission.

Priory Park 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 checked 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 was completed on the 25 and 30 October and 2 and 8 November 2017. On the first day of the inspection the home was being refurbished so the inspection team allowed the home some time to return to normal operations before concluding the inspection. When we returned on the 2 November we were hoping to conclude the inspection and return on the 8 November to feedback to the registered manager following their annual leave. Unfortunately we could not access all the information we required to conclude the inspection in the absence of the registered manager and a regular member of the kitchen team so we completed the inspection and feedback to the provider and registered manager on the 8 November 2017.

The inspection was completed by two adult social care inspectors and an expert- by- experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance they had experience of caring for someone living with dementia.

Prior to the inspection we collated the available information and analysed it to inform our inspection plan. This included notifications sent to the CQC, the Provider Information Return (PIR) and information sent to the commission from the Local Authority safeguarding team. A PIR is a document completed by the provider telling us what they do well and what they hope to improve upon.

During the inspection we spoke with 11 people who lived in the home and six visitors. We spoke with 15 staff including carers, nurses, the deputy, registered manager and area manager. We also spoke with two CHAPs (Care Home Assistant Practitioner), the chef, maintenance person and domestic staff.

We looked at six staff personnel files, monitoring and audit information and records kept to support the safe administration of medicines. We looked at eight people's care files in detail and others to look for specific

information. We also looked at room files to help identify the assessed support needs of people in the home and to see the records of the support delivered.

We completed a Short Observational Framework for Inspection (SOFI) to observe the quality of care provided to those people who could not tell us their views on the support received.

We looked at all areas of the home including communal areas, the laundry, and kitchen and sluice rooms and in people's bedrooms.

Requires Improvement

Is the service safe?

Our findings

When we asked people what they thought of the home, we were generally told they were happy. We were told the staff were nice and treated them well. One relative told us, "[Husband] had a fall recently but is recovering well."

At the last inspection we recommended the provider follow their own policy and procedures in relation to ensuring appropriate checks were made to potential staff suitability. At this inspection we had ongoing concerns in this area. Schedule 3 of the Health and Social Care Act 2008, details clear requirements for providers to follow when recruiting staff, to support vulnerable people. We found the home was not following guidelines to ensure the schedule was implemented in the recruitment of all staff.

We found staff completed applications forms and references and DBS checks were made to ensure there was nothing declared from these sources around the suitability of staff. However, we saw when references identified potential concerns in people's suitability or identified areas that required more consideration this was not always done. We saw the provider had gathered information around some concerns but these had not been developed into risk assessments to manage any potential risks moving forward. We also saw that the terms and conditions referred to a probationary period but there was no evidence in the files to show this had been followed. We also saw where gaps were noted in employment history these had not been explored until the commission requested the information.

The provider continued to not follow their own policies and procedures in relation to the safe recruitment of staff. We had made a recommendation about this at the last inspection which has not been implemented as a consequence we find the home to be in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw one incident where a person was unsteady on their feet when entering their room with a staff member. The staff member pushed the buzzer but nobody came to help. A staff member walked past and they were asked to help. Both staff members supported the person to stand in an unsafe way. We discussed this with the registered manager who contacted us after the inspection to assure us both staff received additional moving and handling training. We discussed with the staff how they supported the individual and both knew it was unsafe. We discussed the moving and handling risk assessment and care plan for the individual and the staff were unclear of how support should have been provided. We reviewed this person's moving and handling assessment and found it had not been updated following recent falls and the care plan had not been updated in the four months prior to the inspection. The moving and handling assessment and associated care plan did not clearly define the current needs of the person and the support staff should provide, to reduce any associated risks. We were assured shortly after the inspection that the assessment and care plan had been updated. The person had a pressure mattress to the side of their bed and a pressure cushion on their chair so staff could be alerted if the person got to their feet and required support.

We reviewed the risk assessments to support people at risk of choking and found these were contradictory.

In one person's nutritional care plan it stated they were a low risk of choking but their dependency profile said they were a medium risk. We reviewed the choking risk assessment and found they were a medium risk. The assessment review stated remained at low risk when clearly on the assessment it stated medium. The risk management plan said food should be cut up and the person should be monitored whilst eating. We saw this person eating biscuits and crisps alone in their room and they were struggling to do so. We spoke to a staff member about this that went into the room to better support the individual.

We saw when people had accidents including falls; records were made in their daily records. An accident form should also be completed and an entry should be made on the home's electronic Datix system. We found this did not always happen. In one file we saw a record of seven falls in three months. Two of those falls had occurred in August 2017 and three in October 2017. There was no record on the Datix system of the five before mentioned falls. This meant the registered manager could not review the action taken and make an informed assessment if any further action was required to mitigate risks.

When risks are not effectively identified and assessments are not consistent with the current picture there is a risk people will not get the support required. When staff do not have clear guidelines on the support they should be providing because assessments are inconsistent and care plans are not updated there is a risk support provided will not be effective. When accidents and incidents are not recorded or investigated appropriately there is a risk the information will not be used to update people's risk assessments and they will not receive the support they need. This is a breach of Regulation12 (1) and 12(2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the information the home held to support people in the event of an emergency. We saw the home had a contingency plan with named locations in the event an evacuation was required. We did not see any risk assessments to reduce the risks associated with emergency situations. These were developed by the provider company and sent to the inspector the following day. We were told the risk assessments would be rolled out across all provider services. We saw each person had a Personal Emergency Evacuation Plan (PEEP) but some of these had not been updated since 2015. We saw from two of these we cross referenced that the needs of the person had clearly changed. For example one PEEP said the person was independently mobile when they no longer were. We saw most staff at the home had been trained to undertake the role of fire warden. However it was not defined who would adopt the role in the event of an incident.
We recommend the PEEPs are reviewed and updated as necessary and a fire warden is allocated for each shift so they were aware of their responsibilities, if the event should arise

We reviewed the records kept to ensure emergency equipment and procedures were fit for purpose including regular checks on fire equipment and bi annual evacuation practices. We saw professional equipment testing had been completed on the gas and electric installations, the equipment used for hoisting people safely and the lift. We also saw all portable electrical equipment had been tested in the last 12 months. We saw the maintenance person tested the water temperatures of water outlets across the home and noted a number of rooms where the temperature exceeded the recommended 41 degrees. We were assured action would be taken to ensure all rooms water supply were kept below the recommended temperature.

We saw each person's file held a dependency assessment of the person's overall support needs. This should be used to determine the staff numbers and skills required to meet those needs. However, we saw that each shift on the rotas we looked at had a different compliment of staff. During the inspection we found there were enough staff to meet people's needs but, we were aware concerns had been noted around the risks associated with only one nurse working the night shift. This had been discussed with the inspector during the previous inspection and assurances were given that this would not occur except in exceptional

circumstances. When we reviewed the rota and spoke with staff we found it happened more frequently. We also found the different staff numbers did not correlate to the needs of the people in the home.

We spoke with the registered manager about the rota and the inconsistencies and were told the rota was not being upheld as they would have liked whilst they were on leave. We were assured a meeting would take place with all trained staff to ensure the rota consistently met the needs of people in the home and was not dictated by staff annual leave and sickness. Another of the provider's homes had recently closed and staff were being offered redeployment to this home, if this was a viable option. We found a clear picture of the staffing levels was difficult to assess as there were a number of additional staff at the home during the inspection from the other home.

We recommend the provider ensures two nurses are on duty at the home every night as dictated by the needs of the people in the home and that they ensure the staffing numbers and skills of those staff are also consistent and allocated accordingly to meet the needs of people in the home.

We observed two medication rounds and found staff were competent in administering medication to the people in the home. The staff administering the medication were respectful and where medicines were as required, staff followed the protocols in place for the individual in receipt of the medication.

We looked at the Medicines Administration Records (MAR) in detail for five people and saw each had a photograph and there was a clear record of any allergies. There were not any gaps in the records, so it was clear if the medication had been administered or not. We saw a signatories list was in place, for the identification of each staff member signing records, to say the medication had been administered.

We checked three medications and counted the medication available against the amount that had been administered and each was correct. There were clear procedures in place for the handling, storage and disposal of medicines. We saw all medicines which were not stored in dossette trays were dated upon opening and all medication had been destroyed before the use by date.

We saw appropriate care plans were in place for people in receipt of medication and were person centred detailing how people liked to take their medicines. Where people received their medication covertly, as in disguised in either food or dissolved in a liquid, appropriate assessment had been undertaken.
We checked how medication was checked into the home and found that some short term medications were only checked in by one person.

We recommend that all medications are checked in by two people to ensure the prescription is accurately recorded on the MAR from the record received from the pharmacy.

On the days of the inspection the home was being redecorated and the lounges on the top floor were being refurbished. We found the home was generally clean and tidy. We looked in the sluice rooms and laundry rooms and did not see any accessible Personal Protective Equipment (PPE) including gloves and aprons.

We recommend PPE is available at points of need and specifically where staff may be handling soiled clothing or continence aids.

We saw the last Infection prevention and control (IPC) audit was completed the month of the inspection by the Local Authority. We saw the audit identified schedules that had not been updated and that the policy required to be updated. We looked in the IPC file and found the actions had not been signed off.

We recommend the provider ensures action from IPC audits are completed to ensure the cleanliness of the home is maintained.

We saw all but four of the staff at the home had completed safeguarding training in the last 12 months. The provider had a policy and procedure available to staff on how to protect people from abuse. We saw assessments were completed when people were supported by restrictive practice including lap belts and recliner chairs. However, we found some of these were completed on the day of the inspection and were rushed. We discussed this with the registered manager who told us they would be reviewed and updated if required.

We saw some records of injuries that could not be explained as they had been unwitnessed. The records had not been updated to reflect the healing of the injury and it was not clear from the record what action was undertaken to reduce the risk of reoccurrence. We discussed this with the registered manager who told us they would review all records for the last three months and ensure appropriate action had been taken and if not would take any required action moving forward.

This key question remains rated as requires improvement.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us the staff were helpful and knew the needs of the people they were supporting. One person told us, "[relative] had a stroke 12 months ago and has massively improved since being at the home. We hope they will be coming home soon."

We asked people about the food provided at the home and none of the people living in the home responded positively. We were mostly told, "It is all the same." And "If I don't like it, I just have to wait until the next meal."

We saw people were weighed monthly, we noted when people were seen to lose weight the frequency of when they were weighed was not routinely increased. We found this meant that on some occasions people did not get the additional support they needed. We saw those who had lost the most weight, in any given month, were named on the white board in the staff office. This meant staff had access to this information.

However, we also noted that all those that lost weight did not all receive the same level of support. For example, of the three names on the white board for October 2017 only one had begun to have their food and fluid monitored. This meant staff were unable to monitor what food and fluid the other two people ate or drank to enable them to provide more of that type. We also saw other people were having their food and fluid monitored and there was no record as to why. We noted there were some records to say people's food and fluid should be monitored and it was not.

We saw some people had been referred to the SALT (Speech and Language Team), where they had been prescribed specific textured diets to reduce the risk of choking and support difficulties when swallowing. We saw these plans were not always followed and in one instance the kitchen staff were unaware of the need for a special diet. We saw the kitchen had a white board with the details of all people living in the home. We cross referenced this information with the information from people's files and saw they were not always consistent. This included one person who was not noted as a diabetic, one that was not noted as a vegetarian and one that was not noted to be in receipt of a specific diet. We discussed this with the kitchen staff and registered manager and were told all diets and preferences would be reviewed and updated.

We saw on two lunch servings there was not a vegetarian option available and the person resorted to eating custard for lunch. We saw another occasion where there was an option of chicken casserole or chicken pie, which was the casserole with a crust on. We noted from the menu that there was generally only one option available to people and there was not any record of an alternative offered when people did not like that option.

We found the home had not taken appropriate action to ensure the nutritional needs of people in the home were effectively met. This is a breach of Regulation 14 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We saw how staff interacted with people when providing support. We saw the staff member routinely checked with the person, prior to intervention, to ensure they were in agreement. For example staff would say, "Do you want to go to the dining room for lunch?" And "Are you ok, to take your medication?"

At the last inspection we recommended the provider ensured that those people giving consent on behalf of people who lacked capacity had the authority to do so. At this inspection we found this action had not been taken. We found consent to care and treatment was not always formalised as it should be. For example, we saw consent forms were not routinely signed by people in the home when they had the capacity to consent to care and treatment themselves. We also saw that when this was not the case, the consent had been provided by someone who did not always have the legal authority to do so.

We saw consent had been given to someone receiving their medication covertly by a family member who only had Power of Attorney for finances and not care and welfare. Likewise family members had signed in consent when they did not have any authority, to sign an agreement, to support provided to their family member. We discussed this with the registered manager and administrator and shared with them how they could gather the information from the office of public guardian. This would ensure moving forward those giving consent on behalf of people who lacked capacity had the authority to do so.

We saw templates for consent to bedrails had been signed but the form had not been completed to say if they were consent to the use of the bedrails or not. We saw signatures for consent to documents that had not yet been completed.

When providers do not gather informed consent to the support and treatment provided, it is not clear that people are aware of their options to refuse or other options of support available to them. When providers do not ensure that those giving consent on the behalf of someone else have the authority to do so, that consent is unlawful. To not have lawful and valid consent from people for the support and treatment they receive is a breach of Regulation 11 of the Health and Social Care Act HSCA 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).

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.

We found the home considered the MCA and assessed people's capacity to make specific decisions. When the assessment detailed a lack of capacity, best interest decisions were made and recorded. We found the home completed and referred people for Deprivation of Liberty Safeguards appropriately and had applied the principles of the MCA prior to doing this. This was better applied to the top floor of the home.

We recommend the provider reviews the implementation of the MCA and ensures practice across the home is consistent

One person told us they had been in the home for eight months but had not been able to see a chiropodist. We discussed this with the provider who told us an appointment would be organised. Other people told us they could see their GP as requested and we saw the provider made referrals to the falls team, continence nurse, tissue viability nurse, and dietician as they felt was required.

When we first arrived on site we looked around the building and assessed the environment for the people being supported. We were told the top floor supported people living with dementia and was being refurbished on the first day of the inspection. We saw the two lounges on that floor had been emptied for redecoration and new furniture. We saw this completed on the last day of the inspection and noted the lounge was homely and clean. On the first day of the inspection the colour of the painted walls on the top floor caused confusion to the eye. The wall had been separated in colour just above a hand rail which was the same colour as the wall behind it. This made the handrail blend into the wall and the line separating the two colours stand out. We discussed this with the provider's area manager. By the last day of the inspection the top floor had been completely redecorated with the wall one colour and the handrail a contrasting colour. This would help people identify the handrail.

There were signs around the home showing the direction of the lounges and bathrooms but further work was required to completely adapt the design and decoration of the floor to support people living with dementia. This included simple things like ensuring orientation items such as clocks and calendars showed the correct date and time and bathroom flooring was changed from the blue lino currently in place. People living with dementia often confuse blue flooring to be water and this can be unsettling and make them uneasy on their feet.

We recommend the provider completes the King's fund enhancing a healing environment audit to make the best use of this space.

We observed how staff and people in the home interacted. We found senior staff were aware of people's needs but some of the newer staff or agency staff were unaware of people's names and the support they needed. We looked at the inductions staff received during their probationary period. We looked in the personnel files with the home's administrator and found only three files contained information about any induction they received. There was evidence to show staff had received induction paperwork at the start of their role but staff had not returned the paperwork to evidence its completion and to be signed off.

We recommend the home ensures staff complete the induction provided and recommend staff are provided (or know where to find) high level information about the people they are supporting immediately upon starting into post.

We reviewed the training and saw comprehensive mandatory training was in place. Most training was delivered through electronic learning and most had been completed. However practical training was not up to date. On the day of the inspection we saw poor moving and handling undertaken by two staff and when we reviewed the practical moving and handling training we found that less than half of the appointed staff had completed it in the last 12 months. We fed back our concerns to the management team who assured us this training would be provided in the months after the inspection for the whole staff team. Staff told us there was additional specific training to meet people's specific needs.

We saw the last team meeting prior to the inspection had taken place in July 2017, we also saw three other sets of minutes for flash meetings which were undertaken to share specific concerns. We saw staff received regular supervision but these were not scheduled in advance and staff did not know when their next supervision was. Shortly after the inspection the registered manager sent us assurances that the supervision

matrix would be further developed detailing staff supervisions past and in the future. We also saw that appraisals had not been completed for staff in the past two years. However, we saw a notice from the registered manager requesting staff schedule appraisals before the end of November 2017.

The rating for this key question remains as requires improvement.

Requires Improvement

Is the service caring?

Our findings

We were attempting to talk to one person and they could not hear us because they did not have their hearing aids in. We asked staff about them and were told the person had not worn their hearing aids for some time. We had to give up trying to communicate with this person as they were becoming agitated at not being able to hear us.
We looked at the care plan for this individual and there was nothing recorded about the use or non-use of hearing aids. We recommend the provider supports people with the use of communication aids regularly especially if people have fluctuating capacity.

During the inspection we saw staff were very busy and we found people were often unattended in communal areas and seating in the corridors. We saw when staff did interact with people they were polite and engaged with people in a dignified manner.

We saw people reading papers and drawing in books on one day of the inspection but there was no other form of activity other than the television, over the inspection. During our observations we observed people sitting in the lounge asleep in chairs and looking withdrawn. We were told new staff were due to start including an activity coordinator.

We did not speak with anyone living at the home or any relatives who had been involved with either developing or reviewing their care plan. However we saw some good person centred information written in people's plans including preferences for their night time routine, food preferences and how they liked to take their medication.

We recommend the provider formalises the involvement of people in developing their care plan and records this at point of review.

Whilst we saw that people were asked about their food preference we did not see any evidence of this being put into practice. When we spoke with people the standard and choice of food was the biggest concern. We were told. "There's only ever one thing on the menu." And "It's always soup and sandwiches for tea." We spoke with the company responsible for the catering at the home and were told the company had recently redeveloped the menu following involvement of people in the home and had developed more appetising options for those on special diets. This included when people were on a pureed diet the food items being pureed separately and presented on the plate to resemble the original foods shape.

We recommend the provider monitors the implementation of these changes and continues to take feedback from the people in the home on both the quality and choice of food available to them.

On the first day of the inspection we saw in each of the floors main bathrooms, a basket of toiletries. We asked what they were and were told they were used if people did not have their own. We discussed this with the registered manager who assured us they would be removed and if it was found someone did not have

their own toiletries, they would be provided solely for their use.

During the course of the inspection our attention was drawn to the quality of the bedding and towels used. We saw many were very thin and some were threadbare. We were assured new linen would be purchased following an audit of what was being used. The provider told us they had recently bought new bedding so they were to check it was being utilised in the home.

We saw staff knocking on doors when entering rooms and asking people their views when engaging with them. But we also saw people shouting from their rooms and staff walking past as if they hadn't heard them. We were told this is when people were going on their breaks or returning to the floor whilst in the middle of delivering support to other people. We were assured that moving forward staff would let other staff know when people were requesting support if they could not provide it themselves.

We saw an advocate was used to support one person and was completing a review on the day of the inspection. We were told the home worked well with them, identifying the needs of the person they were supporting.

At the time of the inspection no one was being supported at the end of their life. We saw some basic end of life care plans had been developed in each of the files we looked in. We reviewed the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records and found each of them completed accurately and involved the person or their appropriate representative in the decision. We also saw the decision for the DNACPR to be a permanent one or one for review had also been correctly signed off by the decision making GP.

The rating for this key question has changed from good to requires improvement.

Requires Improvement

Is the service responsive?

Our findings

We didn't see any focused activities taking place throughout our inspection. We saw an activity coordinator was on shift on one day of the inspection but we only saw them helping out over the lunch time, supporting one person with their meal.

Each person's file had a journal for staff to complete about the important things in people's lives for each day. There was a note on the white board in the staff offices to prompt staff to update these journals twice a week. We looked at the journals in eight files and saw that most of them had not been updated for some time. One we looked at had not been updated for two months. We looked at the daily records for people and found they were task focused and included statements of how well someone had eaten and whether they had an appointment that day. There was no details of how the care plan had been followed.

We saw each person's file had a page on the front to identify clinical hotspots. This identified key risks in supporting that individual. We looked at five of these and found three of them were out of date. Hotspots included if there was a DNACPR in place, if the person had poor mobility or had a special diet.

We looked at charts used to determine positional changes and the food and fluid people had taken and found they were not completed accurately. Where someone was to be repositioned every two hours to reduce the risk of pressure areas developing there were large gaps in records. In one file we saw a record had not been kept of a positional change for seven days.

When records are not contemporaneous of the care provided or are not accurate of the support required there is a risk support needs will be missed or new concerns will not be identified. This is a breach of Regulation 17 (1) (2) (a) (b) (c) of the health and social Care Act 2008 (Regulated Activities) 2014.

Each care file had a high level profile of all care plans. We saw some of these had not been updated for up to two years. This did not allow staff to have an 'at a glance view' of people's support needs.

When we looked in care plans we saw some contradictory information including the assessed risk of people's needs. For example we saw one Waterlow assessment for one person skin integrity and pressure risk scored them as 24 (very high risk) but only the front page of the assessment had been completed. It had not been reviewed and the dependency profile identified pressure damage as a medium risk.

We saw reviews of care records that stated no change when clearly other records identified increased risk. For example, one person had a continence care plan written in 2015 identifying them as occasionally incontinent. The person had received a continence assessment in May 2016 identifying they were then doubly incontinent. The care plan had been reviewed every month to August 2017 and simply stated care plan remains relevant when clearly the assessment had changed some 14 months earlier.

We saw wound care plans which were not updated when there had been additional injuries and body maps

were not routinely used to map wounds and injuries. We saw some body maps were completed upon initial injury but they were not used to monitor or map the healing of the wound.

We also saw medication care plans that were past their annual review date of up to 10 months.

We looked at one person's file that had been in the home approximately three weeks prior to the inspection. We saw that on their day of admission an assessment had been developed for medication, mobility and continence. Each had assessed the person's needs in these areas as high. The person's daily notes held a number of records identifying risks including attempts to walk when they couldn't and the person scratching their legs. A skin care plan had been developed when they were seen scratching their legs and a body map was started. This was reviewed 10 days later which was four days prior to the inspection. We went to review the person's legs and found they were in a very bad state. We reviewed the records and saw a GP had prescribed a medication the person was allergic to and could have been a reason for the person scratching and harming themselves. We discussed this with the nurse and the area manager and insisted the GP was called to review the person's legs and prescribed medication. If the person's condition did not improve we advised the provider to raise a safeguarding alert.

The records to support the risk and support needs for this person were inadequate. We found that care plans were not updated when risks changed, we found risk assessments were not completed in a timely manner when people were admitted to the home and we found assessments and reviews were not always accurate when completed for others in the home. When people's needs are not appropriately assessed and plans are not put in place to meet those needs, there is a risk people will not get the support they need. When peoples' records are reviewed and changes in need are not identified, there is a risk people's changing needs will not be addressed and if required additional support sourced from external professionals to ensure people's needs are met. This is a breach of Regulation 9 (1) of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We saw the home had well developed hospital passports. These documents were used in the event someone from the home was admitted to hospital. The document included clearly identifiable information around people's key health and support needs and their prescribed medication.

The manager told us they had not received any complaints since the last inspection. We saw a complaints policy was in place and a file was set up with available templates for recording, investigating, responding and monitoring complaints.

When we spoke with staff it was clear they knew people well. We were told how people liked to spend their days and who had visitors and when they came. Staff talked with visitors updating them on how their family members had been since their last visit and saw this was appreciated.

The rating for this key question has changed from good to requires improvement.

Inadequate

Is the service well-led?

Our findings

The home had a current registered manager who had been in post approximately three years. A deputy manager had recently been recruited and there were two clinical leads, one for each floor. The home was also supported by nurses and care home assistant practitioners (a role between the nurses and senior carers).

At the last inspection we found the home required improvement for all key questions except caring and responsive which were found to be good. In October last year the home went into a quality review with the Local Authority and clinical commissioning group to help drive improvements. At this inspection we found the quality of the service had declined and the breach as identified at the last inspection remained and the two recommendations made at the last inspection had not been addressed. We also found six breaches to four other regulations.

We looked at the current systems used by the home to share information with the staff team and drive improvement. We found where concerns had been noted and actions had been agreed they had not been delivered for some time after their identification. For example, in the staff meeting held in July 2017 it was identified that wall dispensers were needed for gloves and aprons. On the days of the inspection these were still not in place in the sluice rooms. In the same meeting concerns were noted about moving and handling training and the action was that all new staff would receive the training. We found on the day of the inspection that approximately half of the home's staff had still not received this training in full. Most staff had completed the theory part of the training.

We looked at a fire risk assessment completed in March 2017. The assessment identified some areas of concern and identified actions to be implemented to reduce the risks. There were six priority actions which should have been addressed within six months. None had been signed off on the action plan. We looked at the action with the most risk attached and noted it said the kitchen door should be locked when not in use and that the bedrooms close to the kitchen should be prioritised in the event of an evacuation being required. We cross referenced this with the evacuation plan and it was not noted. We asked two staff about the evacuation of the rooms and they did not know they should be prioritised. We spoke with the maintenance person who showed us the actions had been completed.
A health and safety Audit completed in July 2017 identified the need for staff to attend COSHH training. A monthly food health and safety audit completed in October 2017 identified the training was still required.

When risks are identified and action agreed to reduce risks is not completed then the provider is not taking steps to mitigate risks this is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked the audits and quality monitoring of the home to ensure concerns could be identified. We saw there was a system of audit which entailed audits being completed on the 12 of the month and 25 of the month. However records held in the files were not consistent. Care plan audits were undertaken identifying

what aspects of the care plan were present. The home audited approximately six care plans a month. The home could support up to 40 people. This meant that some care plans would not be audited for over six months. The information from the audits was not collated to identify which aspects of the care plans were mostly missing, there was no action undertaken to determine why certain sections were missing or whether they had been completed upon a re-audit. There were no plans to remedy the situation including potential training requirements for staff.

We saw monitoring records to ascertain if the pressure relieving mattresses were working at their correct setting to support the person using it. We found the records were not completed correctly. We did not see one record which included the correct setting for the mattress being used. Yet staff had said it was correct. One mattress we looked at did not appear to be moving and the mattress was supporting a person with high risk of pressure areas. The area manager removed and replaced the mattress for one where the correct settings could be monitored. The registered manager assured us they would reinforce the correct completion of the paperwork within team meetings and supervision.

The home's maintenance person completed weekly checks on the doors in the building and it was noted they were all up to required standard at the last check prior to the inspection. The magnetic strip was not catching when the door closed to the dementia unit making the unit less secure. Works to be completed were recorded in a maintenance log book did not contain the need for the upper door to the dementia unit to be fixed. The inspector raised this with the area manager and we were told it would be attended to that day.

Monitoring records stated a moving and handling care plan is held in each person's bedroom was scored at 100% prior to June 2017. In July this had reduced to 67%. We did not see any action undertaken as a result in the drop in available care plans. The monitoring had not been completed since July 2017.

We saw monitoring records which stated a care plan was in place for each wound which described treatment regime, pain relief and dressings change plan. The monitoring stated the plan was evaluated monthly or when change occurred. This was not the case.

We saw monitoring which stated bedrails check forms were available in each room and were completed correctly. This was not the case. We did not see one form that was completed correctly. On one form used to check the bedrails it was recording support provided and said assisted with lunch. We discussed this with the registered manager who said they would raise it at team meetings and supervisions.

We found the behaviour monitoring charts were pre populated with the names of staff working the shift. However none of the names were crossed out when an incident occurred so there was no way of knowing who had observed or been involved with the incident. We also saw care plans had been agreed to by a family member when the care plans were not available to be agreed.

The home did not have an effective set of quality monitoring and audit tools. This meant the audits if undertaken were not identifying the concerns within the home. When they did identify concerns action was not taken to determine if the required improvements had been made. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home did have an effective system for monitoring medication which included daily, weekly and monthly audits.

The home completed questionnaires with staff, residents/relatives and professionals.

We saw some completed staff surveys which, whilst were mostly positive but consistently raised concerns with the environment and issues with the food. There were no plans developed to address the concerns raised by the staff.

Staff had completed the last questionnaire with the people in the home in July 2017 and relatives had completed a survey about the same time. The actions against the concerns noted were to discuss at the next relatives meeting. We saw a relatives meeting had been cancelled in April 2017 and one had been scheduled for July 2017. We asked to see the meeting minutes for the July meeting to ascertain if the concerns had been discussed and discovered that meeting had also been cancelled. Concerns raised by people in the home included a low score for; 'suitable activities', 'relative support to go into the community to persue interests' and 'does the relative find the food appetising'. The information had not been acted upon and there were no developed plans for addressing the concerns.

It is a requirement for providers to gather the views of the people using the service and to act on that feedback. We found the provider had gathered feedback from people using the service, relatives and professionals but had not acted on the feedback for over three months this is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the provider was not sending all the required notifications to the commission and found them in breach of this regulation. We received an action plan which stated the registered manager would review all incidents daily to ascertain if they needed to be submitted to the commission. We found at this inspection the registered manager sent notifications based on the information added to the electronic Datix system but it was found at the inspection that not all incidents were being recorded on this system. The provider needed to ensure there was a developed procedure where by all accidents and incidents were recorded in line with the home's policies and procedures, so in turn they could be submitted to the commission as required. We have found the home in continued breach of Regulation 19 of the Care Quality Commission (registration) Regulations 2009.

We spoke with staff who had not been in post very long and others who had worked at the home a number of years. All staff members we spoke with told us they worked well with their peers and felt supported. However, everyone told us the rota could be problematic and when staff called in sick or couldn't come in last minute the shift was not often covered. This was found to be specifically problematic during the night shift. We spoke with the registered manager about this who told us staff were allowed to try and cover the shift. Staff also told the work pattern was not always suitable for example, one staff member told us they could sometimes do every other night for a week which was very difficult with their sleep pattern.

We looked at the rotas for the week of the inspection and the three weeks prior to the inspection. We found that the staffing numbers and allocation differed on most days. For example one day had two nurses from 8am to 8pm, one nurse from 8am to 2pm, three carers from 8am to 8pm and one carer 8am to 2pm. Two days later there was one nurse from 8am to 5pm, two CHAPs from 8am to 8pm and three carers from 8am to 8pm. Two days after that there was one CHAP, 8am to 8pm, three carers 8am to 8pm and one carer from 8am to 2pm. There was no rationale as to why the home was routinely supported by different compliments of staff. On one day of the inspection we looked at the names on the rota and compared this to the names on the white board in each office and found they also differed. When staff details are inconsistent or recorded incorrectly there is no way to promote or manage staff accountability.

We found a number of occasions where staff were not completing the role as required. This included completing people's journals and updating people's records when needs and risks changed.

We recommend the provider ensues there are appropriate and skilled staff on duty to meet the requirements of the regulations.

The provider had a comprehensive set of policies and procedures but many of them required updating in line with new regulations and best practice guidelines. We were told the provider had updated the policies and they were available on the provider's intranet but the registered manager had not printed them off or shared them with the team. When policies and procedures are not 'live' documents and staff are not briefed when they update or change there is a risk staff will be working outside of provider procedures.

We recommend the registered manager ensures policies and procedures are routinely reviewed and updated in line with provider expectations.

The provider was displaying the ratings from the last inspection via a link from their website. However it was noted the website stated the home had capacity for 45 people, yet they are only registered for a maximum of 40 people. We recommend the provider amends the website to clarify the registration.

We found the provider proactive at addressing some concerns noted during the inspection. This included the immediate redecoration of the upper floor in line with good guidance around environments for people living with dementia. The home were using an external contractor for food preparation and delivery and the provider ensured they were available to talk to the inspector during the inspection.

The rating for this key question has changed from requires improvement to inadequate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (registration) The provider had not informed the commission of all incidents as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 The provider had not appropriately assessed the needs of everyone living in the home. Where needs had been assessed, appropriate action was not being taken to meet those needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 The provider had not ensured those people giving consent on behalf of people in the home had the authority to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 The home had not assessed the risks to all people living in the home, where risks were assessed the home had not taken appropriate action to mitigate those risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 When people lost weight there was not a consistent approach to support them. Records kept to support people were not always completed and the kitchen did not have all the information they needed to support people with their nutrition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 The home did not have a comprehensive system of quality audit to identify concerns in the service delivery. The home did not have a contemporaneous record of the care and support required by people in the home, nor of the care and support provided to people in the home. The home did not act on the feedback it received in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 The provider did not ensure all the information required for schedule 3 of the health and Social Care Act was undertaken for each person employed when they were employed. The provider was not following its own procedures and the probationary period was not signed off.