Hampton (Midland Care) Ltd

Midland Care Home

Inspection report

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Date of inspection visit:
26 February 2019
28 February 2019
04 March 2019
05 March 2019

Date of publication:
24 May 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Midland Care Home is a nursing home that was providing personal and nursing care for up to 66 older people, some of whom were living with dementia. There were 55 people living at the service at the time of the inspection; 10 people were residing at the home whilst waiting for assessment for discharge from the local hospital.

People's experience of using this service:

•□People were not protected from the risks of abuse as not all staff had received training in safeguarding and staff had failed or report incidents to the manager. The manager did not recognise when to report allegations of abuse or the significance of unexplained injuries and poor moving and handling; they had not alerted the relevant authorities.

•□There were not enough staff employed to provide people's care; there was a high use of agency nursing and care staff. Staff were not deployed to ensure people received all of their planned care, and ensure that people had appropriate supervision. People's dignity was not always maintained as their personal care was not always carried out regularly or at the planned intervals.

•□The provider relied on agency staff, but did not ensure they had a suitable induction to the service, employment checks, training and competencies required to carry out their roles. Both agency and permanent staff had not always received the training and supervision they required to provide safe care.

•□Staff did not always have information about people's needs as people's risk assessments and care plans did not always reflected their current needs. Staff did not always receive all the information they required to meet people's care safely.

•□People did not always receive their prescribed medicines as they were not in stock. People's medicine records did not have all the information required to enable agency staff to give medicines safely.

•□Staff did not consistently ensure people were offered and supported to eat their meals. People were at risk of losing weight and dehydration.

•□People living with dementia had access to other people's rooms; there were no safeguards in place to prevent them accessing maintenance materials or substances that are hazardous to health. People were at risk of acquiring infections as cleanliness in the home was poor, particularly on the first floor where people lived with advanced dementia.

•□People were not supported to express their views about their care or be involved in creating their care plans. People and their relatives had not been asked for their feedback. People did not have any involvement in the running of the home.

•□People's verbal complaints were not recorded or responded to. The manager did not always follow the provider's complaints procedure; complaints were not always reviewed or concluded in writing.

•□People had not always had the opportunity to express their preferences or wishes for their end of life care. People's care plans did not record people's wishes.

•□•□The provider failed to have sufficient oversight of the home as there were failings in the quality and safety of the care. The provider has no previous experience of nursing homes.

•□There had been failings in recognising when people were unwell and seeking prompt medical attention. A

clinical lead had recently been employed to improve the clinical safety, however, the provider had not given them all the resources they required to implement all safety measures. There was insufficient management or a clinical oversight at night, evenings and weekends.
•□The provider did not have systems to assess, monitor, evaluate and make changes to improve the service. The provider failed to have systems in place to evaluate the quality and effectiveness of deployment of staff.
•□The provider was working within the principles of the MCA, they identified people who required a Deprivation of Liberty Safeguards (DoLS) assessment and made the appropriate applications.

Rating at last inspection: Requires Improvement published 5 December 2018.

Why we inspected: This inspection was brought forward due to information of concern relating to staff's ability to recognise when people were unwell, and people being admitted to hospital with sepsis.

Enforcement: The provider was in breach of nine regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014and one regulation of Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any concerns found in inspections and appeals have been concluded.

Follow up: We will continue to monitor the service and work with partner agencies. The provider will be instructed to provide action plans and reports.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

For more details, please see the full report which is on the CQC website at www.cqc.org.

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.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not caring.

Details are in our Caring findings below.

Inadequate

Is the service responsive?

The service was not responsive.

Details are in our Responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Midland Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was prompted in part by multiple notifications of incidents following which three people using the service were admitted to hospital with suspected sepsis and another person died. These incidents are subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incidents.

However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of recognising illness and sepsis. This inspection examined the clinical oversight and safety.

Inspection team:
The inspection took place over four days by three inspectors.
Day one, two inspectors a specialist advisor (nurse) 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; people living with dementia.
Day two was carried out by the lead inspector.
Days three and four were carried out by two inspectors.

Service and service type:
Midland Care Home is a care home, which provides nursing care. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. Having a registered manager means that they and the provider are legally responsible for how the service is run and for the

quality and safety of the care provided.

Notice of inspection: Unannounced

What we did:
Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people at Midland Care Home.

During this inspection we spent time with and where possible spoke with 15 people who used the service and 11 of their relatives. We spoke with 17 members of staff including the provider, manager, clinical lead, four nurses, two floor managers, four care staff, the chef, the maintenance person and two administrators. We also spoke with a visiting advocate.

We looked at the care records of 26 people who used the service including daily records, medicines records and the assessments and care plans. We also examined other records relating to the management and running of the service. These included five staff recruitment files, agency staff records, training records, supervisions and appraisals. We looked at the staff rotas, complaints, safeguarding records, incidents and accident reports, GP records, communications books, handovers and quality monitoring audits.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse:
- Systems and processes were not consistently followed to protect people from the risks of harm or abuse. The manager had not followed the provider's policies and procedures or kept their knowledge of safeguarding up to date.
- The manager had not raised safeguarding alerts when indicators of abuse had been reported to them. For example, people acquiring unexplained injuries, which could indicate potential abuse or neglect.
- We found other incidents and allegations of abuse where there had been no further investigation or action taken. We found one person had made a complaint to the manager about a possible sexual assault. Another involved unsafe moving and handling practise, these had not been further investigated and not shared with the local safeguarding authority. They had also failed to take appropriate action.
- The provider had not ensured all staff received safeguarding training. Some staff did not understand how to recognise the signs of abuse or know how to report any concerns of abuse. Following the inspection, we raised seven concerns with the local authority safeguarding team.

The provider failed to protect people from potential abuse by having the systems in place to protect service users from abuse or improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Staffing:
- The provider did not employ enough staff to meet people's needs. One family member told us "They [the service] are so short of staff, when we come in, the care staff are relieved to see us, they say, 'now you're here you can take over, we're so busy' and hand us the flannels. It's not safe, there are not enough staff."
- A member of staff said, "There isn't always enough staff on shift. When there's last minute sickness and it can be difficult getting staff in to cover." The minutes of a staff meeting held in February 2019 recorded that staff raised concerns about staffing levels in relation to meeting people's dependencies.
- The provider had calculated the dependency of people in the home for the first time in February 2019, when they allocated staffing numbers accordingly. However, they did not complete any further checks or observations to ensure the allocated staff was sufficient to meet people's needs.
- The provider told us they found it difficult to recruit nursing and care staff and relied heavily on external agency staff. The staff team was supplemented by agency nursing and care staff on every shift.
- Allowances for the layout of the home had not been considered when deploying staff. People could not be seen and rooms were spread over a large area. People who could not communicate their needs or use call bells relied on staff carrying out frequent checks, personal care and providing opportunities to eat and

drink. We observed, and records showed the staff struggled to carry out these frequent checks and provide care in a timely way.

•There was a lack of supervision of people in the communal areas to monitor people and prevent incidents such as falls occurring. Records showed people had fallen in communal areas and sustained serious injuries. For example, on one occasion staff took 10 minutes to notice one person had fallen in the lounge. The CCTV footage showed three people had been in the lounge unsupervised for over half an hour before the fall. Another person fell in a lounge and sustained serious injuries which could have been prevented with adequate staff supervision.

•The provider admitted up to 15 people for short term care for 'assess to discharge' from the local general hospital. These people were recovering from treatment in hospital; they required regular and ongoing assessment to ensure they were discharged to a suitable place of care. The provider had not provided enough staff to provide support and assessment.

•The provider did not ensure there was management or clinical lead oversight at night, evenings or weekends. Nursing staff who were mostly agency oversaw the home at these times; the provider had arranged for the manager and clinical lead to be on-call to provide advice.

•The provider relied heavily on the newly appointed clinical lead; there was no contingency for their absence.

The provider did not employ or deploy enough staff to meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Staffing

Recruitment:

•The provider did not have suitable systems in place to assure themselves that external agency care and nursing staff were of good character and had the qualifications and skills to work at the service.

•Accurate records were not kept on the use of agency care or nursing staff, including their registration with the nursing and midwifery council. For example, the staff rotas referred to agency staff only by their first name. There were no records to support permanent staff in them knowing the knowledge and skills of agency staff.

•Two incidents of possible abuse occurred in the week of our inspection; the manager did not have the details of the agency staff involved.

•Robust systems were not in place to ensure all agency staff received an induction to the service.

The provider did not have suitable systems in place to ensure agency staff were of good character or have the qualifications and competence to carry out their roles. This is a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Fit and proper persons employed.

•The manager followed safe recruitment and selection processes for permanently employed staff. Staff recruitment files contained all relevant information to demonstrate that staff had the appropriate checks in place. The manager ensured all permanent nursing staff were registered with the nursing midwifery council.

Assessing risk, safety monitoring and management:

•People were at risk of not receiving their care as planned or in a safe way.

•Agency staff did not receive sufficient information about how people moved, ate, drank or communicated. This put people at risk of not receiving safe care that met their needs. For example, one person with a known risk of choking required thickener in their drink to aid their swallowing. Agency staff

had assisted them to drink water without thickener, they said they did not know how this person took their drinks. This person was at risk of choking, as staff did not know to thicken their drinks.

•□The provider did not ensure people's risk assessments and care plans always reflected their current needs. One relative told us, "Staff still treat [relative] as if he is still independent, his care needs have changed he needs a lot of help now." This person's care plans did not reflect their current behavioural, personal care or nutritional needs.

•□People did not have risk assessments, care plans or protocols for the management of their diabetes. Staff did not always record people blood glucose levels or record when they gave people their insulin. One person had been admitted to hospital in December 2018 with complications related to the mismanagement of their diabetes. People were at risk of not having their diabetes safely managed.

•□Staff told us and records showed staff had started to review all the risk assessments and care plans, which had last been updated in August 2018, but this was going to take time to get through all of them.

•□The provider had not protected people from substances that could be hazardous to their health. People living with advanced dementia walked into all areas of the home where they had access to thickener, denture cleansers and washing up liquid, they were at risk of accidentally ingesting these.

•□Some rooms were undergoing repairs and refurbishment, these rooms contained maintenance tools; these rooms were readily accessible to people living with dementia as these were not locked. People were at risk of harm from access to maintenance tools.

Using medicines safely:

•□The provider did not have systems in place to ensure the safe management of medicines.

•□Records showed 16 people had not received their medicines in the two weeks prior to our inspection, due to their medicines being out of stock. People were at risk of their health deteriorating or symptoms such as pain or seizures as medicines controlling blood pressure, epilepsy and pain relief were amongst the missing medicines.

•□People did not always receive their newly prescribed medicines in a timely way. For example, antibiotics prescribed by the GP would not be delivered as planned. The provider did not have a system to collect prescriptions or medicines where these were prescribed late in the day. People were at risk of not receiving essential medicines in a timely way.

•□People's medicine administration records (MAR) did not have a photograph of the person they related to. This increased the risks of agency staff administering medicines to the wrong person.

•□People prescribed medicines to be taken 'as required' did not have protocols for staff to refer to, to explain when and why they would give these medicines. People were at risk of being given medicines for sedation without a clinical reason, and assessments of the effectiveness could not be measured.

•□Staff did not record where on the body they administered people's prescribed transdermal medicine patches or insulin injections. The provider had not implemented any systems to mitigate known risks associated with not rotating areas of administration of injections and patches.

The provider did not have systems in place to assess risk and do all that was reasonably practicable to mitigate such risks or manage people's medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safe care and treatment.

Preventing and controlling infection:

•□The provider did not have sufficient systems in place to maintain cleanliness in the home.

•□There were not enough cleaning staff deployed to clean 66 bedrooms, en-suite bathrooms, corridors and communal areas.

•□People living with advanced dementia were living in an environment where good standards of cleanliness

were not always maintained. People and their families told us the sheets were rarely changed. We observed that some people's bedding and mattresses were unclean. There were unpleasant smells in many areas of the home.

•□Staff were seen not always washing their hands between providing care or changing gloves between tasks as required in the provider's infection control policy.

•□Staff did not ensure rubbish bins in the medicine's rooms were emptied, leading to overflowing bins. The provider had not taken action to manage the overflowing bins including clinical waste in the car park at the front of the home.

•□One third of the care staff had not received training in infection prevention.

The provider did not have adequate systems in place to prevent or control the risk of infection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safe care and treatment.

•□There had been an outbreak of diarrhoea and vomiting in December 2018 where 17 people had been affected and 12 staff. The provider had informed the authorities and taken all the right steps to contain the outbreak.

Learning lessons when things go wrong:

•□The provider had used learning from incidents in November and December 2018 to improve the clinical safety of people. A permanent clinical lead had been appointed who implemented a clinical observation (early warning) tool to identify people who were unwell. However, the provider had not ensured they had all the resources they required to implement the system.

•□The provider did not use the learning from complaints, audits or people's feedback to improve the quality of the service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Supporting people to eat and drink enough to maintain a balanced diet:
- People had been identified as at risk of losing weight or dehydration. However, people were at continued risk of losing weight or dehydration.
- Nursing staff did not always review the people's fluid records to assess whether people had received sufficient fluids. People at risk of urine infections were not given enough to drink to achieve their calculated daily fluid targets, which were set to help prevent urine infections.
- People did not always have access to drinks. People in bed did not have access to their drinks and people in communal areas relied on drinks rounds.
- People who required pureed food and thickened drinks that helped prevent their risk choking were put at risk as staff were not always aware of who required these. People were at risk of not receiving the correct consistency of food and drink to prevent them from choking.
- People who required meals to meet their cultural needs received these three times a week as the provider sourced authentic Indian food from a local Hindu centre. However, one family continued to buy their own food from the same centre their relative wanted Indian food every day. The provider told us they were considering extending this provision to daily.
- Staff monitored people's weight; where people had lost weight, they had been referred to their GP and dietitian for assessment and advice. People's food was fortified with milk powder, whole milk, cream and butter to increase the nutritional value of their meals. However, when people declined their food at mealtimes, staff did not offer food at other times, which meant that some people were left for long periods of time without eating.
- Where people received their nutrition via a percutaneous gastrostomy tube (PEG) feed, staff recorded they followed their prescribed feeding regime. However, staff did not record they had provided all the care required to ensure the PEG tube site was cleaned and rotated daily to prevent complications and infection.

The provider did not have adequate systems in place to ensure people's nutritional and hydration needs were met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.Meeting nutritional and hydration needs.

Staff support: induction, training, skills and experience:
- The provider did not ensure that all staff providing care had the skills and competencies to provide safe care that met people's needs.
- The provider did not ensure all agency staff received an induction to the service. Staff told us the quality and competence of the agency staff was very variable.

•□The provider did not ensure all agency nurses know of their procedures for identifying and acting upon deteriorating health. The provider had implemented a safety procedure to monitor people's deteriorating health which included a clinical observation tool. However, the staff were not using this correctly and missing the key signs when people became unwell.
•□Staff had access to induction and training provided by the provider. However, due to the shortage of staff, they could not always access the training as they were required to work instead.
•□The provider did not have systems in place to ensure staff received essential training when required such as fire safety and safeguarding. Staff had recorded incidents in people's daily notes but had not reported these to the manager as a safeguarding issue. This put people at risk, as staff did not have the training to know how to keep people safe and the action to take in the event of a fire.
•□People who required assistance and equipment to mobilise, at times had staff move them that were not trained in safe moving and handling. One member of staff told us, "I'm usually with another member of staff when we use a hoist." However, they were unable to tell us if the other member of staff had received training in moving and handling, as they told us they did not check. The manager told us they had witnessed unsafe moving and handling when reviewing the homes CCTV footage.
•□People living with advanced dementia, at times received care from staff that had not received training in dementia awareness. Staff did not always have the skills and knowledge to know how to best care for people living with dementia.
•□Staff had not received appropriate supervision or appraisal in the last year.
The provider did not ensure staff received sufficient support and training to enable them to carry out their roles. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Staffing.

•□The new clinical lead had recognised the issues with staff supervision and implemented a programme of supervision from February 2019; five members of staff (6%) had received supervision in 2019.

Adapting service, design, decoration to meet people's needs:
•□On the dementia care floor, some people were cared for in bed. Safety gates were fitted across the doorways to help prevent other people from walking into their bedrooms. However, we saw some of these gates were loose or open and people could still access other people's rooms.
•□Some people chose to lock their bedrooms from the inside. One person told us they chose to lock their door as it made them feel safer. Staff had a master key to open the doors to check people were safe.

Supporting people to live healthier lives, access healthcare services and support:
•□Training had been provided for nursing and senior care staff to complete a clinical observation tool. However, the system relied on the clinical lead being available to supervise and monitor these records as the practise had not been embedded, and there was a turnover in agency staff.
•□The local NHS Clinical Commissioning Group (CCG) had arranged for staff to access medical advice and clinical assessments via a telephone and video service linked to a central GP assessment centre.
•□A paramedic associated with the GP surgery regularly visited the service to carry out assessment and prescribe medicines, such as, antibiotics. However, delays collecting prescriptions had placed some people at risk of worsening health whilst waiting to start a course of antibiotics.
•□Staff had referred people to the GP who visited the home on regular occasions.

Ensuring consent to care and treatment in line with law and guidance:
•□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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

•□We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

•□The provider had suitable systems in place to identify people who required a DoLS assessment and made the appropriate applications. Three people had DoLS authorisations in place and the manager ensured they received their care in accordance with the conditions.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Inadequate:People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Ensuring people are well treated and supported; respecting equality and diversity:
•Although the provider tried to get regular agency nursing staff to provide continuity of care, this was not always possible, and people regularly received care from agency nursing and care staff they did not know.
•Where people did know staff, they had a good relationship, but did not have the opportunity to spend time with each other as there were not enough staff to allow this.
•Signs of emotional distress were not always recognised by staff. For example, we observed one person who was new to the service was in a high state of anxiety. They were asking for help, staff walked passed the person numerous times without acknowledging their distress and did not provide any reassurance.
•One person who we observed over four days, could not communicate verbally. They were usually seated alone. One day they were seated in a communal area; staff were sitting at a nearby table. The person was making noises and trying to get their attention; the staff ignored them. This person did not have companionship or anything to occupy them.
•One person could not communicate verbally and was cared for in bed. They continually tapped their cup on their bedside table. Staff occasionally stepped into the room to ask what they wanted, but when they left the room the person continued to tap their cup. This person did not have companionship, or any means of distraction or anything to occupy their time.
•Three people were sat at the dining table during the morning in their wheelchairs and remained there throughout the day. There were minimal interactions with these people and no activities or interactions offered.
•Staff did not always communicate with people when supporting them with their meals; people lost interest in their food.
•People did not always receive their clothes back from the laundry. One relative told us, "We've lost so many clothes, [Name] is being discharged today in someone else's clothes, as they have none left."
•One person relied on their mobile phone to call their relatives, this had been reported missing but no action had been taken to look for or replace the phone. This person was distressed at not being able to contact their relatives.
•People living with dementia did not always have access to their glasses. Three people's glasses were stored out of reach above their medicines cabinet in their rooms. These people were not encouraged to use their glasses.
•Staff had collated 27 pairs of glasses and one hearing aid into a basket; none of these were named. People's belongings had not been respected and people were left without their glasses and hearing aid, preventing them to see or hear clearly.

Supporting people to express their views and be involved in making decisions about their care:
•□People were not supported to express their views about their care.
•□People were not involved in creating their care plans.
•□People had not been asked for their feedback about their care.
•□People who only spoke their native language, that was not English, did not have their care plans or information about the service provided in their own language. No attempt had been made to provide this information in written, picture or recorded verbal form.

Respecting and promoting people's privacy, dignity and independence:
•□People's dignity was not always maintained as their personal care was not always carried out regularly or at the planned intervals. People were at times left in soiled clothing until staff were available to provide personal care.
•□People were not always supported to have regular baths or have their hair washed. There were not enough staff to provide regular baths.

The provider did not ensure people were treated with dignity and respect, or support autonomy. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Dignity and respect.

•□People received their care in the privacy of their own rooms.
•□People living on the second floor had a small group of staff that knew them well. They had good relationships; staff knew people's likes, dislikes and preferences.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- People's care plans did not always reflect their current needs or preferences. They were not reviewed regularly or as people's needs changed. Where staff had updated people's care plans, the old information was filed with the new information, making it difficult for staff to understand what people's current care needs were.
- Staff had not involved people or their families when updating the care plans to ensure they agreed with their care plans.
- People's preferences were not always known by temporary or agency staff, as the handover they received did not provide this information.
- Staff had access to a summary of people's care plans in each room, however, these were not always reflective of all their needs and preferences.
- People did not always receive their care as planned. Agency staff did not always have all the information they required to know what care to provide.
- Due to the shortage of staff, people had to wait for their care until a member of staff was available.
- People did not always have access to their call bells; they could not summon help. Where people were unable to use their call bells, planned checks by staff were not always carried out.
- People at high risk of acquiring pressure ulcers did not always receive regular support to change position to relieve pressure points.
- Repositioning charts stated people required their position changing every four hours. However, records showed some people waited between nine and 12 hours for staff to help them change position in bed. Staff told us agency staff did not always know what care people needed, some people's care was missed. Some people had acquired pressure ulcers since moving into the service.
- People with urinary catheters did not always receive the care they required.
- People's care notes stated people were at high risk of infection and required regular fluids and monitoring of their urine colour and output. There were no records of the colour of people's urine, which would indicate their level of hydration. People did not always receive their target amount of fluids every day. There was no clinical oversight of this, or actions taken to improve people's intake.

The provider did not provide care that met people's needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Person-centred care.

- People took part in group activities provided by the activities staff and visiting entertainers.

Improving care quality in response to complaints or concerns:

- The provider failed to ensure there was a robust system for dealing with complaints.
- Relatives told us they had complained verbally to staff and the manager about cleanliness of the home, staff conduct, lack of personal care and opportunities for bathing, people not receiving enough to drink and staff not responding when people became unwell. These complaints had not been recorded or responded to.
- Relatives told us staff and the manager advised people to put their complaints in writing. One relative told us, "I'm too tired to put it in writing, it's too draining. I have told them [manager] what the problem is, but I've not had a response." Another relative told us, "I've told [manager] but nothing changes."
- Staff had raised complaints about the lack of staff and the effect this had on the quality of people's care. The manager had not addressed these concerns as staff continued to complain about this at staff meetings.
- People and their relatives had complained in writing about lost items such as glasses, hearing aids, clothing and mobile phones. Their complaints had not always been responded.
- Records of complaints showed the manager had begun to investigate concerns but had not concluded the complaint in writing. The manager did not follow the provider's complaints procedure.
- The provider had not used issues raised in complaints to change practice and improve the service.

The provider did not operate an effective system to identify, receive, record, handle or respond to complaints. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Receiving and acting on complaints.

End of life care and support:

- People had not always had the opportunity to express their preferences or wishes for their end of life care. People's care plans did not record people's wishes.
- Some people had been admitted to the home for end of life care. They had been assessed for their needs and medicines were provided for symptom control.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

- The registered manager had de-registered with the Care Quality Commission (CQC) in July 2018. The provider appointed a new manager in August 2018, however, the manager did not have the knowledge and skills to manage a nursing home. The manager had failed to complete the application process to register as a registered manager.
- The provider failed to have sufficient oversight of the home and there were failings in all areas of people's care and treatment.
- During the period between September and December 2018 the home did not have a clinical lead, this led to a lack of clinical oversight resulting in incidents involving people being admitted to hospital, some with suspected sepsis. The provider had not sought help or advice from Local Authority Commissioners or the NHS Clinical Commissioning Group (CCG).
- Following concerns raised by relatives and staff in December 2018 the CCG assessed the nursing needs of people using the service and worked together with the provider to implement an action plan to improve safe care and treatment.
- The manager was responsive to the CCG's feedback, but the systems implemented required time to be embedded. The provider recognised the service was not performing well and stopped taking any new admissions.
- The provider had employed a clinical lead in January 2019. The provider passed all responsibility for clinical governance to the clinical lead without providing all the resources they required to implement the necessary changes. The provider started to admit people to the service again before the clinical governance systems had been fully implemented or embedded.
- The provider failed to understand the importance of implementing and embedding systems designed to keep people at the service safe, before admitting more people to the home.
- The provider failed to listen and respond to staff concerns about the lack of staff.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- The provider failed to have sufficient systems and processes in place to assess, monitor and evaluate the quality and safety of the care people received. The provider did not have systems to improve the service through continuous learning and re-evaluating.
- The provider failed to provide sufficient managerial and clinical oversight of agency nursing staff who were often left in charge of the home in the evenings, nights and weekends. The provider did not have sufficient systems in place to monitor and assess agency staff skills and competencies, or have records of

which agency staff were providing care.
•□The provider failed to have systems in place to ensure people's risk assessments and care plans reflected people's current needs. There was a lack of clear communication between staff to ensure they had all the information they required to meet people's needs.
•□The provider did not assess and monitor the effectiveness of the safeguarding and complaints procedures. This had impacted on people's safety as people were not safeguarded from the risks of abuse and could not rely on the service to respond to their concerns.
•□The provider's systems to monitor the deployment of staff did not identify people were not getting their care as planned or that people were falling in communal areas; they were not being supervised by staff. There were insufficient systems in place to monitor and assess people's falls, accidents and incidents.
•□The provider failed to monitor training and supervision; they failed to notice not all staff had the skills and competencies to provide safe care. Staff had not received training or support to carry out their roles safely.
•□The provider's audits failed to identify the poor management of medicines. People did not always receive their prescribed medicines.
•□There was insufficient oversight of the accuracy of people's care records relating to their daily care, health and behaviours.
•□The provider did not have suitable systems to keep people's care records secure; these were stored in communal areas in unlocked cupboards.
There was a lack of oversight of infection control procedures.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
•□People and their relatives had not been asked for their feedback. People did not have any involvement in the running of the home.
•□Staff meetings took place regularly since January 2019; these had helped improve communication. These meetings prompted discussions about identifying areas for improvement and implementing new systems.

Working in partnership with others:
•□The NHS Clinical commissioning Group (CCG) had highlighted clinical concerns during their visit in December 2018. The CCG had given the provider an action plan to improve the clinical safety of the service. They had also provided the on-line GP service. The clinical lead had begun to implement the action plan used the on-line GP service, however, there was so much change required to the staffing and infrastructure that the provider struggled to comply with the CCG action plan in a timely way. The provider continued to work with the CCG to understand how the service should be improved.

Continuous learning and improving care:
•□The provider did not have systems in place to audit and analyse accidents, incidents, falls or complaints; they did not have the information to learn from these or take steps to improve the service.

The provider failed to have systems and processes to assess monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

•□The clinical lead had put in place systems to protect people from clinical risk. They had commenced a risk register detailing people who required specific medical attention for their risks of ill health. The risk register was shared with senior staff, who met regularly to discuss. However, the register had not been embedded into practice on all shifts or the significance understood by agency staff.

•□The clinical lead had implemented regular meetings for senior and nursing staff to discuss how best to manage people's medical care. These had been successful in introducing protocols for identifying when people's health deteriorated. However, the provider relied on this one person to implement all clinical procedures without additional support required at weekends and nights.

Statutory notifications:
•□The provider failed to notify CQC of seven incidents of unexplained injuries since 1 January 2019.
•□The provider failed to notify CQC of three Deprivation of Liberty Safeguards (DoLS) authorisations.

The provider's failure to notify CQC of incidents which could indicate abuse or improper treatment, and DoLS authorisations is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

•□The provider had displayed their rating from their previous inspection at the service and on their website. People, visitors and those seeking information about the service could be informed of our judgements.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider did not provide care that met people's needs.

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider did not ensure people were treated with dignity and respect.

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not have systems in place to assess risk and do all that was reasonably practicable to mitigate such risks or manage people's medicines safely.

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	The provider did not have systems in place to protect service users from abuse or proper treatment.

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider did not have adequate systems in place to ensure people's nutritional and hydration needs were met.

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider did not operate an effective system to identify, receive, record, handle or respond to complaints.

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to have systems and processes to assess monitor and improve the quality and safety of the service.

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The provider did not have suitable systems in place to ensure agency staff were of good character or have the qualifications and competence to carry out their roles.

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not employ or deploy enough staff to meet people's needs

The enforcement action we took:

We imposed conditions on the provider's registration. These prevent new admissions and re-admissions to the home.