Flintvale Limited

# The Green Nursing Home

## Inspection report

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20 September 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| 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

This inspection took place on 19 and 20 September 2017 and was unannounced. The Green Nursing Home provides accommodation for up to 59 older people who require nursing or personal care, and who may be living with dementia. At the time of our inspection there were 46 people living at the home.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered nominated individuals, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager of the service had left in July 2017 and the home was being managed on a day to day basis by the Nominated Individual who is a person who has legal responsibilities to ensure the service runs safely and well, and is the representative of the provider. At the time of our inspection there was also an acting manager who told us they planned to apply to become the Registered Manager. They were volunteering their time at the service and had not yet been employed by the company.

The home was last inspected in May 2017 when we found the provider was not meeting the requirements of the law in four areas. Of the five key questions, we rated four as Requiring Improvement and the key area of Safe as Inadequate. We spoke with the provider's representative and the registered manager following our inspection in May 2017. We asked them to send us an action plan detailing what actions they would take to improve the service. We returned to the service to undertake this comprehensive inspection six weeks before the work detailed in this action plan was due to be completed. We expected to see that improvements were well underway and to gain confidence that the improvements would be completed within the time scale on the action plan. At this inspection we did not find that improvements had been made in line with our expectations. This inspection found the provider was not meeting the requirements of the law in four areas. Of the five key questions, we rated three as Requiring Improvement and the key areas of Safe and Well Led as Inadequate. The provider had failed to secure adequate improvements to improve the safety and quality of service provided to people.

Prior to our inspection we had received a larger than expected number of safeguarding alerts in relation to The Green Nursing Home. We worked closely with the local Clinical Commissioning Group (Part of the NHS) who were providing nursing support and visiting the home regularly. They provided us with information about the safeguarding concerns and how they had been addressed. During our inspection we found that when a safeguarding alert had been made it was dealt with appropriately. However we were not confident that all areas of concern had been identified by the service as safeguarding issues. We found that four peoples care was not safe and had not been recognised as such by staff. The poor management of wound care was highly concerning and people were experiencing inadequate care and medical intervention. After the inspection safeguarding alerts were made to the local authority by the inspection team in relation to these concerns. We are awaiting the outcome of these.

The provider had failed to consistently notify us when they were legally required to do so.

People told us they felt safe. We saw safe techniques were used to move people. Staff understood the risks to people's health and safety but risks such as support to people who had skin wounds were not always managed well. Recording of these risks was not always evident. There were sufficient staff to meet people's needs, although some people felt that more staff were needed on occasion. The provider operated a safe recruitment system which meant people were supported by suitable staff. Staff understood their responsibility to raise concerns regarding potential abuse.

People told us that staff had received training to support them, but the support was not consistent. Staff understood the need to ask for consent and we saw that they asked people before providing any care. The Nominated Individual had started to apply the principles of the Mental Capacity Act, but some people may have been unlawfully deprived of their liberty as applications to do that had not been submitted when deprivations were identified. People's nutritional needs were being met. People had access to some health professionals when their health needs changed, however we were not confident that all healthcare needs were well met.

People were supported by kind and considerate staff. People had some day to day choices about their care and staff listened to them and respected their choice. People were not always treated with dignity and respect by staff. Staff encouraged people's independence where possible.

People received care which was not always responsive to their individual needs Improvements were required to ensure people's care records contained up to date and accurate information about the care they received. People and their relatives told us they felt comfortable raising complaints with the Nominated Individual, and we saw there was a formal complaints process in place.

Although people told us they were happier with the care provided they had not been included in any of the on going or proposed improvements. People had not been involved in planning or reviewing their care. The governance system had only just started to be implemented and had not been effective at the time of the inspection. The nominated individual did not have a full awareness of the extent of the problems and issues which needed to be addressed. It had also not been effective in improving quality or mitigating risks.

During this inspection we found that provider to be in breach of four regulations. You can see what action we told the provider to take at the back of the full version of the report

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we told the nominated individual 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?

**Inadequate**

The service was not consistently safe.

People were not kept safe as some people experienced harm that may have been avoidable.

People were not kept safe as risk assessments were missing or not followed.

People were supported and cared for by sufficient numbers of staff in many but not all parts of the home.

People received most of their medicines well, but the management of skin creams, patches and PRN medication was not safe.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People had consent sought in day to day matters but applications to deprive some people of their liberty had not been made.

People were supported by trained and skilled staff.

People had enough to eat and drink.

People could access health care professionals.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were not supported in planning or making decisions about their own care.

People did not always have their dignity maintained.

People were treated kindly by caring staff.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People did not receive a service that was personalised to them.

People were not supported to follow their interests or hobbies.

People felt that the service had a complaints process they could use.

## Is the service well-led?

**Inadequate**

The service was not consistently well led.

People did not live in a service that included them in the planning or reviewing of their care. People were not included in decisions about how the home was run, or how their care was delivered.

People were not supported by a quality assurance and monitoring that led to improvements and mitigated against risks. Due to this some people were put at risk of receiving unsafe care.

Accidents and incidents were not recorded and acted upon in a way that meant further accidents would be less likely to happen.

The provider had not notified us of events as they were legally required to do.

# The Green Nursing 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 nominated individual is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 September 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor who was a trained 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. On the second day the inspection was undertaken by two inspectors.

As part of planning the inspection we checked if the provider had sent us any notifications. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We also looked at any information that had been sent to us by the commissioners of the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also spoke with the local Clinical Commissioning Group [Part of the NHS] and examined the information we hold in relation to the provider and the service. We used this information to plan what areas we were going to focus on during our inspection visit.

Due to their specific conditions many of the people who used the service were not able to speak with us so we observed how staff interacted with them. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection visit we spoke to 14 people who lived at the home. We spoke with the Nominated Individual and the acting manager. We talked with 11 members of the staff team, including two nurses. During the inspection we spoke with three visiting health professionals and nine relatives of people. We sampled various records, including people's care records, staffing records, complaints, medication and quality monitoring. After the inspection visit the manager sent us information that we had requested which we reviewed in order to help us reach our judgements.

Inadequate

# Is the service safe?

## Our findings

At our previous inspection of this service we found the key area of 'Safe' to be Inadequate. These concerns were identified as three breaches of regulation within this key area. These were breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach of Regulation 18 concerned the numbers of staff that were available to support people. At this inspection we found this had improved and the breach has been met. At the last inspection we found that Regulation 12 safe care and treatment and Regulation 13 safeguarding were in breach. At this inspection we did not see sufficient improvements within these areas. The service remains in breach of Regulation 12. Most people were protected from the risk of abuse when management were aware of the concerns because referrals to the local authority were made to protect people. However, some people were receiving poor care at The Green Nursing Home and this had not been recognised as poor care or perceived as a safeguarding concern. These people had not been kept safe We remain concerned for people's safety, but found the specific issues related to the previous breach of regulation 13 had been met. Due to the ongoing breach of Regulation 12 and other serious concerns found at this inspection, we found the key area of Safe remained Inadequate.

During our last inspection of this service we found that people had not been kept safe from avoidable harm as many people had experienced injuries as a direct result of staff wearing jewellery and having long finger nails. These events had not been reported as safeguarding. During this inspection we found that this had improved and injuries of this nature were no longer of concern. One member of staff told us, "Agency staff did not want to cut their finger nails so the manager sent them home." During this inspection we also found that staff were aware of the processes to report safeguarding and had received training in relation to it. Staff we spoke with clearly understood their responsibility to raise concerns regarding potential abuse, and all said that they were confident that appropriate action would be taken to protect people if needed.

We found that some people were not receiving safe care. We looked at the wound care records of four people and found that they had risk assessments in place. However the risk assessments were not being followed by nursing staff. For example one person had a wound on their leg that records stated needed to have the dressing changed every 2 to 3 days. We saw that the dressing had not been changed for ten days prior to our visit. In another instance a different person's wound had significantly increased in size over a three week period and there was no assessment of the wound or evidence that it had been dressed during that time. When we spoke with a nurse and asked why so many days had been missed, they replied, "I do not know my dear." We found that people had not been kept safe as their risk assessments had not been followed. These concerns had not been identified by the staff and no actions had been taken to rectify them. We raised this with the Nominated Individual and acting manager and found that they were not aware of these on-going concerns that had caused harm to people. Following the inspection these issues were raised with the local authority as safeguarding alerts by the inspection team.

During our inspection we found that where people had risks to their health and safety the nominated individual had not ensured all risk assessments were in place for staff to deliver care safely. We noted that many people had risk assessments for nutrition, falls, tissue viability, moving and handling and choking which were generally reviewed monthly. However not everyone had all the risk assessments they needed to

keep them safe. For example, one person chose to sleep in chair every night. The person had serious health issues that may have been worsened by not having their legs raised at night. There was no risk assessment in place to manage this or a care plan to mitigate against the risks and avoidable harm the person might be experiencing. We also looked at two records of people at risk of experiencing damage to their skin. For these people, regular repositioning was needed to alleviate pressure on their skin to keep them safe and well. One person's care plan did not state how frequently they should be repositioned, and we saw that they were identified as being a high risk of skin break down due to their health needs. We found that the repositioning was recorded on their charts with large gaps, so that we could not be sure if the person was turned regularly to keep them safe. Another person who shouted for long periods of time when they became upset did not have a care plan about their behaviour or information for staff on how to support the person when upset. We found that not all people had risk assessments in place that would provide guidance for staff to keep them safe. Staff we spoke with and care practice we observed showed that staff were responding to people's needs inconsistently.

We looked at the recording of the accidents and incidents within the service and saw that a central record had been kept. We noted that not all the accidents that we were aware of had been listed in this record. We asked the nominated individual how they reduced the likelihood of each accident happening again and what measures had been put in place to avoid them recurring. While the nominated individual was able to tell us of some measures that had been implemented in individual cases, there was no record of the actions taken. The required actions, such as removing bed sides or the closer monitoring of people had not always been put in place to reduce the likelihood of accidents recurring."

We found that people were not receiving care and treatment safely and that the service was not assessing risks appropriately or taking actions to keep people safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that staffing levels had improved since our last inspection in May 2017, but they still felt that more staff were needed at certain times. One person said, "There are times when they are short staffed." Another person told us, "I stay in my room and it's okay until they are short staffed then I have to wait longer." Since our last inspection the numbers of people living at the service had reduced and the numbers of staff had increased, which meant that staff had more time to spend with each person. One relative said, "The home is in transition, the ratio of staff to people is better, there's better staffing levels." Another relative said, "I worry about mom's safety less now as there are less agency staff." People and relatives told us that their call bells were responded to quite quickly. During our inspection we observed the communal areas of the service and we saw that there were sufficient staff on duty to respond to people in a timely manner. However we noted that some areas of the communal lounges were not always observed by staff. One person often sat in an unobserved area, and her relative said, "My Mum is unable to shout for help which she needs to go to the toilet. I am concerned because if she cannot get help she will try and get up herself and will then fall." We observed other people within the home stand without the support of staff, when this was known to be a risk. We spoke with the nominated individual and noted that they had plans to change the deployment of staff within the home to make sure that all areas had sufficient levels of staffing.

People told us that they received their medicines when they needed them. One person said, "They bring me my medication regularly and always stand and watch until I have taken it. I can have painkillers if I ask for them." Another person told us, "My medicines are bought at a better time now." The service had begun using a new system of administering medication and we found that the medicines being administered from this system were done so safely. A staff member said, "The new system is very nice, very safe, and very easy."

We observed medication rounds and saw that they were carried out in a calm, safe, unhurried and

appropriate manner. The nurse made sure they were speaking with the right person and that they knew what the medicines were. It was clear that nursing staff knew the preferences of how people like to take their medicines. Medicine was stored safely in locked trolleys in a locked medicines room. Controlled drugs are medicines that require special storage and recording to ensure they meet the required standards. We found that controlled drugs were stored securely and recorded correctly. Boxed medication was used safely and records showed people were given their oral medicines as prescribed. Staff told us they were confident with their role. Only nursing staff administered prescribed medication and a nurse told us that she had attended medicines administration training annually and her competency to administer medicines safely was assessed by the manager annually.

Some people that take medicine only 'when required' or PRN are expected to have clear protocols in place to provide staff with enough information to know when the medicine should be given. These protocols were not available on the day of our inspection for staff to use. The nominated individual told us that they were currently being prepared, and we noted that the introduction of the protocols was detailed in the action plan the provider had sent us prior to the inspection. On one person's records we saw information that described how they experienced pain when they had their wound dressed. There were no PRN protocols in place to advise staff to give pain relieving medication before changing the dressing and records showed that the person did not have any such medication when their wound was redressed. We also noted that nursing staff were not using a system of assessing people's pain levels. Not having such a system may have meant that some people were not being given their prescribed medicines for pain and may have experienced pain unnecessarily.

We noted that some people needed patches applied to their skin to maintain their health and wellbeing. We looked at how the service was managing this and found that not everyone who used the patches had a system of rotating the places they were put on people's bodies. We spoke with a nurse who could not tell us where the patches had been applied, they said, "I don't know where the night staff put them." They also told us there was no method of showing their rotation, such as a body chart. People who use patches need to have them placed on different parts of their body to make sure the medicines are absorbed into the body well. We also found that people who used skin creams did not receive that care consistently. One person who needed regular application of skin creams to keep them well applied every day had only had the cream applied five times in 30 days. We asked a nurse how the person's skin was and they told us it was very sore. They could not tell us why the creams had not been applied or how those omissions would have been noticed if they had not been drawn to their attention by the inspection team.

People told us there had been improvements in how they were cared for which meant they now felt safer. One person said, "I feel quite safe here with the staff to help me, they are very attentive." Another person told us, "I don't have any concerns, this is my chair and I sit here all day, I think I am quite safe." Not all relatives felt that the improvements had been sufficient however, and one commented, "We as a family are not confident that [my relative's] care is as good as it could be and that all their needs are being met. We visit every day to check and do whatever is necessary to make their life more comfortable." We found that improvements had been made with how people were supported to move safely within the home. Some people needed the assistance of a hoist or wheelchair and we noted that the equipment had recently been serviced and that during all of the moves we observed people were supported safely and well by attentive care staff.

Requires Improvement

# Is the service effective?

## Our findings

At our previous inspection of this service we found the key area of 'Effective' to require improvement. These concerns were based around people with more complex needs not being supported well to make decisions, and that some people's healthcare needs were not well understood within the staff team placing people at risk of ineffective care. At this inspection we found that the service had not made all the required improvements and continued to require improvement in this key area.

Staff gave us mixed responses about how well the staff group communicated with each other. One member of staff said, "If you have had days off, you get a handover, communication is good." Other staff told us that communication between the nurse team and the carers was not good enough. A staff member said, "Not all the staff operate to the new rules so it's hard to work together…its stressful."

We found that communication between staff was not always effective. As part of the improvement plans the existing processes were being updated by new processes, however not all staff understood or knew about the changes. For example, a nurse was not aware that there was now no longer a requirement to have emergency equipment available for immediate use within the home. Also during our inspection we saw that nurses were using one method to record the weights of people, albeit with significant gaps in the recording, but a new method was in use that they did not know about. Communication between nursing staff was also ineffective as the monitoring of wound care did not take place effectively.

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). When people lack mental capacity to make certain decisions, any decision taken on their behalf must be in their best interests and the least restrictive as possible. 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 that for the majority of people the necessary applications to deprive someone of their liberty had not been submitted. Following our inspection the nominated individual submitted the applications as required. Of the people who had received authorisations in relation to DoLS, we found that staff were unclear and systems were not in place to support people in line with their deprivation of liberty safeguards. This meant that some people may have been deprived of their liberty unlawfully and other people may not have been kept as safe as required as staff did not know what to do for each individual person.

Care staff adhered to the principles of the MCA in day to day care and we observed and heard staff seeking

people's consent before they assisted them with their care needs. We noted that staff were skilled and knowledgeable in how to do this to ensure the best outcome for the people they were supporting. For example staff gave people choices about where they sat in the home, if they wanted to join an activity or to be assisted to eat their meal.

People told us they enjoyed their food. One person said, "The food is good, there is sometimes a choice, but I am never hungry. I do get lots to drink." We saw that meal times were an opportunity for people in the communal parts of their home to socialise should they wish to. Another person said, "There is always plenty to eat." The atmosphere at lunchtime was calm, relaxed and unhurried. Staff were heard to offer choices and when plates were cleared people were offered second helpings. People were asked what they would like to eat after they had sat at the table. Some people chose to eat in their arm chairs, others in their rooms and some people sat at the dining tables. The meal choices were also written on a black board in the lounge area, and staff told us people had the option of two main meals a day. We could not be sure however that all people were given choices about what they ate. People gave us inconsistent responses when we asked them if they had been given a choice of meal. One person said, "I don't get asked what I want to eat they just bring it to me." Another person told us, "The food is nice but they just bring me what they think I will like." Relatives told us, "They don't ask her what food she wants they just bring her something." and "They tend to bring drinks around but do not ask first if she wants one, something is just put in front of her." Although we noted that hot drinks should be offered with the lunch we did not see this happen on the day of our inspection.

We found that the specific dietary requirements that people had were not always known to staff. For example, one person had been seen by a Speech and Language therapist who recommended a soft diet due to health concerns. This was not recorded in the person's care plan, and the person was eating meals that had not been appropriately prepared to assist to safely eat. A health and social care professional we spoke with told us that they had to point this out to a nurse before the recommendations were implemented. Another health care professional said, "The catering staff get our recommendations, but I'm not always confident the staff have the knowledge needed [to support people with their food and drink as required.]"

People were supported by staff who had received most of the training to meet the needs of their role. One person told us, "I think the staff understand my needs." One relative said, "Mum has improved since coming here and is now much more responsive. I think this is because the staff are stimulating here much more and motivating her." Another relative said, "Mum is doing okay here, she has to be hoisted and pushed around in a chair and this is always done calmly." We saw that there were some small gaps in the training record of some staff, but all the staff we spoke with felt that they had the skills they needed. Staff we spoke with said they had received training, one staff member said, "I feel like I have the skills I need."

Staff informed us about the induction they had received when they first started working at the service to prepare them for their role. This two week induction period included essential training and working alongside a more experienced member of staff to enable the new member of staff to get to know the people and their needs and wishes.

The nominated individual told us that staff were not completing the care certificate. (A nationally recognised induction course which aims to provide untrained staff with a general understanding of how to meet the needs of people who use care services.) The nominated individual explained that they intended to make sure staff were qualified to a level above that of the Care Certificate. At the time of our inspection however this had not begun, but we were told of plans about how this would be implemented.

Staff told us they received supervisions and support from senior members of the staff team. One member of

staff said, "[The manager] tells us if we are doing well and if there's a problem they tell you what you can do better." We saw records that showed that supervisions were conducted with staff on a regular basis.

People had access to routine healthcare and during our inspection visit we saw that various health professionals visited people as needed. We saw that people were supported to access a range of health care support which included, district nurses, GP, Speech and language therapist, (SALT), dietician, dentist and physiotherapy. One health care professional told us, "I do the reviews; there is a rota of when I do them." Another healthcare professional told us that they felt that communication within the service needed to be improved. They explained that although they were due to visit staff did not know to expect them and this meant that people were hard to locate within the building and were not be ready for their support or assessment. We found that people received healthcare but the lack of effective communication meant that it some cases health appointments were missed for example a person not seeing a dentist and another person missing their appointment with their GP.

Requires Improvement

# Is the service caring?

## Our findings

At our previous inspection of this service we found the key area of 'Caring' to require improvement. This was because staff did not always promote people's dignity with personal hygiene and when moving people and people were not always reassured when they became anxious or distressed. At this inspection we found that the service continued to require improvement in this key area.

People we spoke with gave us mixed comments about the care they received. While many people were very positive some comments were less than good. People said, "We get lots of attention from the staff, they are good girls, they are really polite and helpful." However we also received comments from people such as, "The staff are generally very good, occasionally they can be abrupt." and "The staff are really busy and most are nice but some can make me feel like I'm a nuisance. That's why I stay in my room out of the way." and "The staff are ok but they do tell me off if I ask too many times for things." Relatives told us they found the staff to be kind and caring but one relative said, "The staff are stressed and this is reflected in the care." Another relative told us, "I think the staff generally do care." and a member of staff said, "I think things are improving and the staff are generally good and caring."

People could not be confident that their views would always be listened to and acted on. We saw that residents meetings or similar events to try and include people in the running of the home had not taken place. There were no systems in place such as a key worker system or similar to ensure that people were listened to and their views acted upon. Information to people had not yet been provided in a manner that was accessible to them such as large print, although we were told this would soon be developed. . The nominated individual was not consistently working in partnership with all people as much as reasonably practicable, to support them to make informed decisions about their care and environment.

People were not always treated with dignity and respect. For example, one relative told us, "I do get a bit concerned as there are sometimes people in the lounges that are quite loud and have challenging behaviour. I have known them to be screaming for over half an hour which is not good for them and can be upsetting for the people around them. The staff do often try and calm them down and deal with it and sometimes take them away. I have never witnessed staff reassuring other residents afterwards or checking if they have been upset by this." The dignity of the person who became upset and the impact on the well-being of other people in the home had not been considered. The impact of these instances had not been reduced by practical measures the service might have implemented such as supporting people with different needs in different parts of the home. When we spoke with the nominated individual they told us of their plans improve this situation, but these had not yet been implemented. At the time of our inspection no actions had been taken to lessen the negative impact some distressed people's behaviour had on other people living in the home.

We found some further examples of people not being treated with dignity or respect. We saw that early in the morning some people were dressed in dirty and stained clothes. People had not been supported to

attend to their appearance and we observed people with unkempt hair, some men who were unshaven and people being left with dirty fingernails. On a different occasion we saw that a person was served their meal with the plate of food being placed on the bed beside them, and no offer of a tray or table to assist them to eat with dignity or comfort.

During our inspection we did see examples of people being supported to maintain their independence where possible, such as being encouraged to walk or sit with the least amount of support needed. One person said, "The staff are really kind and helpful.  They let me do what I can but help me when I need it." People and relatives told us that they were made welcome within the home and we saw a small kitchenette had been provided where relatives and friends could make drinks and spend time with the people they were visiting. Staff told us how they maintained people's privacy while offering them care and we observed and heard staff to be discreet when people needed assistance with personal care.

During our inspection we observed interactions between staff and people which were warm and compassionate. They reassured some people who were anxious and distressed and responded promptly, calmly and sensitively. We noted that staff communicated with the people effectively and used different ways of enhancing that communication by touch, ensuring they were at eye level with those people who were seated, and altering the tone of their voice appropriately.

Requires Improvement

# Is the service responsive?

## Our findings

At our previous inspection of this service we found the key area of 'Responsive' to require improvement. We found that people could not be confident their complaints and concerns would be recognised, recorded and acted upon. People could also not always be confident that staff would know their individual preferences and choices. At this inspection we found that while some progress had been made, we have rated the key area of responsive as Requires Improvement again as further improvements were needed.

Some people had expressed preferences that had not been responded to by the management team, or staff. For example one relative told us, "My mum does not like [a specific drink.] We have asked repeatedly for her to be given [a different type of drink] but time after time she is given the wrong one." Another relative said, "We have asked numerous times if the epilepsy medicine my mum is being given by syrup; which has a horrible taste, can now be given by tablet instead. She had tablets at home but it was changed when she was unable to eat and drink in hospital. She is now having lots of tablets again and could easily swallow this but instead is forced to drink this awful tasting syrup. No-one seems to be very responsive and this has been going on for ages."

People were not consistently supported to maintain their interests and hobbies and were at risk of social isolation. One person said, "This is my corner here and I sit here every day. Occasionally someone will play a game with me or a singer will come in but not very often. I usually just sit here and watch the cars come and go in the car park." Another person said, "I don't really have much to look forward to or get involved in so I sit here and wait for my daughter to come." One person told us, "I really like being here, the staff help me get about and take me out to the pub for lunch, so I am very happy."

We saw that the service employed a number of activity co-ordinators but their role was not well defined or co-ordinated. We observed individual interactions between the activities staff and people. On this one to one basis we saw that the staff were skilled and people clearly enjoyed time spent with them. During the inspection we observed a bingo session, which was very slow to start and people seemed impatient. It was then interrupted by one of the nurses who stopped the session to ask the activities staff complete an administrative task. People then lost all interest and either became restless or fell asleep. On discussion with the activities person they were quite unhappy with the delays and interruptions saying "This is not how it should be, how are we supposed to organise entertainment if we are interrupted and delayed." Activity staff then told us that they usually helped with food, drinks and care and said, "We don't get many activities done." Staff also said that people were not involved in planning any activities and that any plans that were made were rarely followed. People who spent long periods of time in their own rooms had no scheduled support. Staff told us that people had short 'pop in' type visits. This left people at risk of being socially and emotionally isolated.

We found that some people did not always get the right support when they needed it. For example one relative told us about asking for a small and inexpensive piece of equipment approximately four weeks ago that would help keep the person safe. The equipment had still not been made available to the person.

Another relative said, "[My relative] lost her top set of teeth when she was really poorly in hospital. We asked four months ago if a dentist could come and sort out some more for her so she can eat properly again. We are still waiting so she has to have food that she can manage to eat."

We found that people who had behaviours that might be considered challenging had not been supported with appropriate care plans, and staff did not have sufficient information or guidance to respond well to these people's care and support needs in a way that was personal and appropriate to them. We found that one person chose to sleep in a lounge chair every night. When we spoke to the nursing team about this they were not aware of it, and it was not recorded by them in the person's notes. We found that no actions had been taken to respond to the person's needs, and no attempts had been made to find out why the person did not use their bedroom. Subsequently nothing had been done to support the person to be more comfortable in the lounge chair where they slept every night. We raised this with the nominated individual who told us that they would ensure the persons needs and comfort would be addressed immediately.

People's needs were assessed before they moved into the home and the information was used to draw up a care plan. The care plans included some information about the person, stating people's preferences and choices relating to their daily routines and their care. Carers we spoke with discussed people kindly and demonstrated that they knew everyone's routines, likes and dislikes in such matters as dressing and food preferences. One carer said, "Some people can't tell you what is wrong, but you can tell by little changes in their behaviours that something is not right." We could not be sure however that people or their representatives were involved in, or contributed to their plans of care as they were reviewed. People we spoke with told us they had not been invited to take part in reviews. One person said, "We talk mainly about the weather". No one we spoke with could recall any of the staff talking to them about their earlier lives, employment, family or particular interests. Records we looked at did not show that people had been involved in any way other than general conversation and the nominated individual could not tell us of a system that gathered people's views about their care or any changes they might want.

The nominated individual had not taken effective action to ensure people received person centred care and is in breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people invited us into their rooms, and we saw they were personalised with items such as photographs and ornaments of importance to them. The nominated individual discussed the recent change in staff and said that the staff now represented a more multicultural group to reflect the needs and preferences of people living at the home.

We saw that the service had a complaints policy and the nominated individual told us that it was going be printed in large print and given to people who wanted it. People and relatives we spoke with said that being able to complain and feeling listened to was improving but more work was needed. One person said "There have been problems in the past but the new manager has made a big difference and she is sorting out everything I have discussed with her." One relative said, "I get an answer to my complaints but its early days with the new managers. "Another relative, "We have had a big meeting recently where lots of people have expressed their concerns and views." Other people and relatives did not feel that things had improved enough and commented, "I do feel there should be a proper complaints/grievance procedure where if you raise a concern it is dealt with professionally and you get feedback so you know you are being taken seriously," and "We do have to ask repeatedly when we want something to change and every time it seems to be forgotten." Staff told us that they felt that complaints were being dealt with better. A member of staff said, "They would deal with complaints well I think." We saw that complaints and concerns were recorded and monitored, and noted that any interventions were taken in a timely manner and where appropriate the nominated individual had apologised to the complainant.

Inadequate

# Is the service well-led?

## Our findings

At our previous inspection of this service we found the key area of 'Well Led' to require improvement. People could not be confident that the auditing and monitoring process to mitigate risks, improve quality or to adequately maintain contemporaneous and accurate records was effective. At this inspection we found that this had not improved and the service remains in breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the key area of Well Led to be Inadequate.

We found that there were very few auditing and monitoring systems in place to drive improvement within the service, and none that involved people. We noted that meetings had taken place to involve relatives and a survey of relatives had taken place May 2017. However there was no system of collecting feedback from people, or gaining their views about the care they received. We did not find that people were actively involved in their care or the running of the service as much as they could have been. Consultation with people and effective ways of gaining their opinions had not been considered. People had not been empowered to make decisions other than in day to day matters, and in many situations people's care was not personalised to them or responsive to their needs. People were not involved in their on going care planning or reviews and no surveys of people's opinions had taken place. We found that the service did not proactively involve people in the running of their home and did not put people at the centre of their care.

During our inspection we found some new auditing and monitoring activities had begun. These were very new and had not yet had time to have a positive impact on the quality of the service. They included medication audits which started August 2017, a cleaning audit started in September 2017, and an infection control audit completed in September 2017, by an NHS professional. It was clear that the nominated individual had begun to develop an auditing and monitoring process. We also saw records made by the maintenance staff that checked that the environment was safe for people. We saw up to date records of fire evacuations, smoke alarm test and other tests for water and electrical appliances. There was no system however of the Nominated Individual checking that these records had been completed or were accurate. We found that while the checks in these areas had been completed an auditing process of them was not yet in place to make sure they continued to be effective.

The majority of the service was not subject to any effective system of assessment or monitoring and in many cases this had resulted in negative impacts for people. For example there were still no audits or monitoring of care plans or risk assessments which had meant that people received unsafe care. We saw there was a lack of clinical oversight of monitoring people's records, which meant that action was not always taken when clinically needed to keep people safe and well. When we discussed these issues with the Nominated Individual they acknowledged that this was an area of considerable concern.

Accidents and incidents that had occurred in the home had not all been recorded. Those listed had not been effectively used to prevent or reduce the impact of the accident happened again. We saw that there were some examples of management reacting to an individual accident or near miss, but this indicated that leadership was reactive rather than proactive. We found that very few auditing and monitoring systems were in place to mitigate against risk within the service.

During the inspection we looked at the applications that had been made by the service to deprive people of their liberty under the Mental Capacity Act. We found that that of 46 people living at the home, 34 people had not had DoLS applications submitted for them. It was unclear as to how many people needed to have applications submitted and no auditing or monitoring of this process had taken place. This meant that some people were being deprived of their liberty without the correct authorisation to do so. This was unknown to the service at the time of inspection, but when we brought it to the attention of the Nominated Individual we noted that they began to submit the applications as required.

The assessment and monitoring of the service to mitigate against risk and drive improvement was not in place. This is in the breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The Nominated Individual had ensured that an effective notification system was in place and while we had received the majority of notifications as required, some had been missed. We found two notifiable events that had not been sent to us since the last inspection. It is a legal requirement that the inspection rating is made available and we saw that the report was on show in the reception area of the home. The provider's website also had links to our report, but we noted that the provider had not followed our guidance in relation to this.

The provider had failed to consistently notify CQC of incidents as expected. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager who was present at our last inspection had left the service and the nominated individual told us they were in the process of recruiting a new registered manager. The person identified was working in the home on a voluntary basis. During the time the home has been without a manager the nominated individual had managed the service on a day to day basis. We recognised that that the service was in a period of transition and we saw that plans were in place to begin improvements to the service. However they had not effectively addressed some of the fundamental concerns we raised in our previous report. The provider had continued to demonstrate that they did not have appropriate oversight to deliver the required improvements for people living at the home.

People told us they knew there was a new manager but were not really sure what was happening, comments included, "I have seen a man walking around who I assume is the manager but he has never spoken to me," and "There is a new lady manager who seems to be organising everyone but I have not chatted with her." Relatives told us that the acting manager had spoken with them, they said, "I think the new manager is trying to get to grips with things but it is early days."
Relatives had mixed views about how the home was run. Comments included, "I've been very pleased with the home, the staff are excellent." and "Whenever I go to the office they seem to know very little and just refer me back to the nurses," and "I am not convinced it is very well led as there is very little joined up thinking and no-one seems to know for sure what is going on. We wouldn't need to keep asking for things if it was well led."

Staff we spoke with knew how to raise concerns or whistle blow and were able to explain the circumstances where they would raise concerns to ensure people's safety. However they had not recognised the need to challenge or question some of their practices which were unsafe or failed to value people as unique and individual. This indicated a lack of understanding of the principles and values of good care within the staff team.

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<br><br>The provider had failed to consistently notify us as they are legally required to do so. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure that people received person centred care. People had not been involved in their care or their environment as much as reasonably practicable. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not provide care and treatment in a safe manner and had not ensured that people were consistently protected from harm. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have an effective monitoring or quality assurance process that drives improvements and mitigates against risks. |

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have an effective monitoring or quality assurance process that drives improvements and mitigates against risks. |

**The enforcement action we took:**

We told the provider that they must return information to us on a monthly basis as specified. We told the provider that they could not admit or readmit service users without the prior agreement of CQC until further notice.