London Residential Healthcare Limited

Chestnut House Nursing Home

Inspection report

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16 October 2017
18 October 2017

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Ratings

Overall rating for this service	Inadequate

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

The inspection took place on the 12, 16 and 18 October 2017 and was unannounced.

The service is registered to provide accommodation and residential and nursing care for up to 85 older people. At the time of our inspection the service was providing residential care to 48 older people some of whom were living with a dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection, the service was rated Good overall. At this inspection we found seven breaches of the regulations.

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. 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.

Prior to our inspection, we received information of concern about staffing levels in the home and standards of care.

People did not consistently receive safe care and treatment. Allegations of abuse were not always reported to the safeguarding authority as required. This was because the adult safeguarding procedures in place were not followed. This potentially placed people at risk of further harm or abuse.

Risks to some people were not consistently assessed or managed to keep them safe. People particularly at risk were those people living with dementia, those with specialist diets and those people with complex mental health needs and behaviours.

The deployment of staff was ineffective and was not always consistently safe to meet people's needs and protect them from harm.

The management of medicines was not consistently safe as people did not always shave access to their prescribed medicines. There were gaps in the records of the administration of medicines and protocols for "when required" lacked detail of actions that staff needed to follow before administration.

People's rights were not protected because staff had not acted in accordance with the Mental Capacity Act 2005 (MCA). Conditions of authorisations to deprive people of their liberty were not being met.

Staff did not receive training and support to carry out all aspects of their roles. Staff did not receive training to support people living with dementia that required positive behaviour support.

Improvements were required to support people to drink safely and to monitor people at risk of poor hydration.

People were supported to access healthcare services when needed.

People and relatives spoke highly about some staff. Some staff spent time with some people and treated people with kindness and compassion.

However not all people were treated with dignity, respect and care at times was task led. Some care provided was not person centred.

People did not always receive care that met their needs and preferences.

Some people took part in social activities or were supported by staff to reduce social isolation.

Concerns and complaints were not always responded to identify how the service could be improved.

The provider did not maintain accurate, complete and contemporaneous records. People's daily monitoring charts were incomplete and included gaps and omissions.

There was not an open and transparent culture in the home. Audits and quality assurance systems did not always identify shortfalls in the requirements of the regulations being met.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report. 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.

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 always safe.

People's identified risks were not consistently managed.

Medicines were not managed appropriately and people were not adequately protected from abuse or harm.

Staff were not appropriately deployed to meet peoples' individual needs.

Is the service effective?

Requires Improvement

The service was not effective.

People's rights were not protected.

Some people's nutrition and hydration needs were not effectively monitored or met.

Staff were not supported to meet all aspects of people's needs.

People's health care needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind and caring. However, not everyone was treated with dignity and respect.

Some care provided was not person centred.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care as outlined in their care plans.

People had the opportunity to participate in activities inside the home.

Complaints and concerns received did not always identify improvements.

Is the service well-led?

Inadequate

The service was not well-led.

There was not an open and transparent culture in the home.

The systems in place to monitor the quality and safety of the service and drive forward improvements were not effective.

Notifications had not been made to CQC.

Chestnut House 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by concerns shared with us about staffing and the standards of care at Chestnut House Nursing Home.

This inspection took place on 12, 16 and 18 October 2017 and was unannounced. The inspection was completed by three adult social care inspectors, with two inspectors present at one time and a pharmacist inspector.

Before the inspection we reviewed previous inspection reports. We also reviewed other information we had received about the home, including notifications. Notifications are information about specific important events the service is legally required to send to us.

We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We gathered this information during the inspection. We obtained the views of the service from the local safeguarding team and Clinical Commissioning Group prior to our inspection.

During the inspection we spoke with two people, one person's advocate and 10 relatives about their views on the quality of the care and support being provided. Some people were unable to tell us their experiences of living at the home because they were living with dementia, and were unable to communicate their thoughts. We therefore 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.

We spoke with the registered manager, the nominated individual, the operations manager and 15 members of staff. We also spoke with five visiting health professionals.

We looked at care documentation relating to nine people, four people's records of social activities and support from staff, 18 people's medicines administration records, five staff personnel files, eight members of staff training records and records relating to the management of the service including quality audits.

Inadequate

Is the service safe?

Our findings

Eight out of 10 relatives raised concerns about how people were being cared for. One person told us they had been treated roughly by two members of staff. They said, "I am scared." Another relative told us they had witnessed a member of staff being rough with someone. We reported these allegations of abuse to the local authority safeguarding authority. At the end of our inspection the safeguarding authority or Police had not concluded whether these allegations were substantiated. The provider told us following the inspection that two members of staff had resigned and one member of staff had been dismissed following incidents at the home.

Allegations of abuse had not been managed appropriately. Allegations of neglect were not reported to the local authority adult safeguarding team and to CQC as required. These allegations of neglect had been made against two members of staff. The allegations included these staff not responding to a call bell, people not being supported to drink, one person left in soiled clothes and someone at risk of pressure sores not being repositioned The registered manager had responded to these allegations by holding a meeting with the two staff involved to discuss the allegations made. The actions noted from these meetings were that both staff's performance would be reviewed in a month. The additional supervision of these staff was not carried out. The registered manager was not at work when this information was found and was not able to explain why they had not reported these allegations to the safeguarding authority as required. This potentially placed some people at further risk of harm as concerns about staff practice had not been monitored. Staff told us that actions had been taken to address other abusive practice by some staff by them no longer working at the home. Incidents of physical abuse between service users had not been reported to the safeguarding authority or CQC as required.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not aware of the risks people faced or how these risks should be managed. Staff told us they were not aware of all risks for people and how to manage the risks that people faced. One member of staff told us, "I am not aware of a behaviour management plan." Another member of staff who had been hit and kicked during our inspection told us, "we weren't told about any risks to us".

People's choking risks were not managed safely. Some people in the service were prescribed thickening agents to help prevent choking when drinking. Different types of thickeners were prescribed. Staff when asked were not aware that these different types needed to be made up in different ways. The kitchen staff were given information by the care team as to who needed any specialist diets such as what texture and consistency of foods for people who were at risk of choking. However a healthcare professional raised concerns with the registered manager about someone at risk of choking being given food with whole grapes in it. This person's needs for a modified diet had not been shared with the kitchen staff.

People identified as having behaviour that challenges and who posed a risk of hitting other people were not supported to meet their needs and safeguard other people. Staff did not take action to keep other people

safe. We looked at the care records for four people who staff identified as having behaviour that challenges. For one person there were six incidents recorded of them being physically aggressive towards other services users over a two week period. This included them throwing cups, throwing a table and hitting other service users.

We observed people who required staff to supervise them to keep them safe unsupervised. A relative raised concerns about how a person who presented risks to others was supported. There was conflicting information about how risks should be managed. A senior member of staff told us this person needed a member of staff with them at all times. However the registered manager told us that no one who lived in the service required one to one care. The registered manager told us they would review this. During and following our inspection two service users sustained injuries from other service users, as risks that two other people presented to others was not adequately assessed.

People at risk of falling were not supported adequately to keep them safe. One person living with dementia and who was wearing loose slippers fell during our inspection and sustained a fracture. Following the inspection the provider supplied information indicating that this was the person's choice. The fall was witnessed by staff who responded promptly to assist the person.

Advice from healthcare professionals was not always followed. Advice from a tissue viability nurse had not been followed in ensuring that pressure wounds were measured to enable clinical evaluation. We looked at the records for one person with three wounds. This meant there was a risk that the improvement or deterioration of wounds could not be assessed adequately and treatment plans reviewed. Some photographs of wounds were also unclear which meant the condition of the wound was unclear. The provider told us following our inspection that they would take action to address this. This put people at risk of unsafe care and treatment.

Arrangements were in place for the safe storage of medicines including those that require temperature controlled storage and those that require additional security. The service had arrangements in place to use homely remedies. These are medicines that can be bought over the counter for the treatment of minor illnesses. These medicines were available to be used and there were clear records when they had been used.

The management of medicines was not consistently safe. People may be put at risk through not having their prescribed medicines and medicines administered were not always recorded. We observed staff administering medicines in a safe way and records of administration of these medicines were made at the time. Records of medicines to be administered did not always reflect the information contained within the medicines care plans or the MAR charts. Some medicines were recorded as not being available to administer. The records showed that these medicines had not been re-ordered until after the medicines had run out.

Care plans relating to 'when required' medicines were not complete. The plans lacked the detail of actions and assessments that need to take place before administration. When these medicines were administered no record was made of how the decision to administer had been taken or the outcome of the administration. A medicines audit had not identified all of the issues that we had identified. We also found that there were some items within the medicines rooms, including medicines that were no longer within the expiry dates as specified by the manufacturer. This could mean that people were exposed to either an increased risk of infection or that they may be given medicines that may not work.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff, relatives and visiting healthcare professionals told us there were not enough staff to meet people's needs. Concerns included people not being supported to maintain their personal hygiene, being neglected, people not supported to drink and delays in support with continence care. One healthcare professional told us, "There are not enough staff as people have specialised needs." Staff told us the staff team tried their best but there were not enough staff to supervise people and people's needs. Other comments from staff included, "There are not enough staff around. No way can we support them with only four to six staff" and "Lots of residents are still in bed when they shouldn't be". One healthcare professional told us, "Today is not good, people are not up and dressed". Eight out of 10 relatives told us there were not enough staff. One relative told us, "I was there for six hours the other day and not once did [their relative] get taken to the toilet". A health care professional told us, "There are not enough staff to monitor people".

Another relative told us they were concerned their relative's care needs were not being met. One healthcare professional shared concerns with us that they were not always confident care had been provided. They found one person had dried faeces and was finding it difficult to sit down. There were no records of care provided for this person on this morning but staff told them care had been provided. The registered manager told us they were looking into these concerns .The provider had implemented a dependency tool and based on this tool had assessed that there were enough staff to meet people's needs. We raised our concerns throughout the inspection about how staffing was deployed in the home to meet people's needs and keep them safe. During the inspection one person was found in another person's room causing harm to this person. This incident was reported to the safeguarding authority and Police. Both people lacked capacity to keep themselves safe. The registered manager and provider told us they thought there were enough staff to meet people's needs.

Call bells were not always promptly responded to and there were delays in care being provided. People told us they often had to wait to receive assistance from staff. For example, for one person who was cared for in bed they pressed their call bell three times over a period of four minutes and it was silenced each time without any staff attending to them or talking to the person. This person required medicine to assist with breathing difficulties. Two staff told us if the call bell is turned off outside of the person's room by a member of staff it automatically rang again to alert staff after two minutes. We observed the call bell was not answered but the person was able to get the attention of a member of staff walking past their bedroom and a nurse supported them to take their medicine. We observed one person being assisted at 11.30am and just before midday with personal care on two days of our inspection. Staff confirmed the person had not already received care prior to this on these mornings.

Another person told us staff tried their best but they had to wait sometimes for their call bell to be answered. They said, "The call bell is not always answered. I get a bit sore". Staff raised concerns that call bells had not been responded to for 10 minutes. For people who were unable to use call bells, staff were required to carry out checks of them every 30 minutes. These checks had not taken place. We checked monitoring records of 30 minute checks for four people. These checks showed gaps of two and a half hours. The records of 30 minute checks for one person the previous month showed gaps on five days. One healthcare professional told us, "They [the care staff] are not regularly checking their room". People were put at risk because systems in place to ensure safe supervision were not being followed.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have robust systems to obtain all information to confirm if staff employed were of good character as required. Disclosure and Barring Service (DBS) checks were made before staff started working at the service but there were gaps in checks on full employment history. Interview records for staff

recruitment did not score the applicant's answers in accordance with the provider's interview checklist to assess skills and knowledge or comment when applicants were not able to answer questions. This meant there was a risk that all checks had not been made to assess applicants' history and skills to work at Chestnut House Nursing Home.

Requires Improvement

Is the service effective?

Our findings

People's rights were not protected because staff did not act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) when seeking consent to care. The 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 interest and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The provider did not act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. There were conditions attached to the DoLS authorisations for two people. Care homes must follow the Deprivation of Liberty Safeguards otherwise this is unlawful. One condition was that the covert medicines for one person should be reviewed each month with their family and representative. This condition was not being met. A senior member of staff told us this had not happened but could not explain why it had not happened. For another person a condition of their DoLS authorisation was that they must be supported to go outside regularly was also not being met. Two staff responsible for organising support to people to go out told us they were not aware of this condition. Activities records for a five week period recorded the person being supported inside the building only. This person presented behaviour that challenged and had been distressed during this period. One healthcare professional told us, "Take [the person] into the garden and they are a different person".

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people lacked capacity to make decisions or give consent, staff did not act in accordance with the MCA. Mental capacity assessments and best interest decisions had not been fully completed in line with the principles of the MCA. There were gaps in mental capacity assessments of people's capacity, least restrictive options had not been considered and those with legal authority had not been involved with decisions. For example, a best interest's decision had been made for one person in relation to the use of bed rails for their safety. There were gaps in the assessment of this person's capacity. The best interest decision recorded the person had a lasting power of attorney, deputy or court of protection order but did not record who had legal authority to make decisions. We asked a senior member of staff who told us, "[the person] has no family who visit but [the person] has a solicitor". This was not recorded on the best interest decision and the care file did not include any information about an appointed power of attorney.

These shortfalls were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive support from staff who had the knowledge and skills they needed to carry out all aspects of their roles. There were people living with dementia at the home and some of those people needed positive behaviour support from staff due to their dementia. Staff told us they had not received training on how to support people with behaviour that challenges. The registered manager told us visiting health professionals had also raised concerns about how some staff supported people living with dementia and offered to provide specialist training. We saw poor practice at times with three staff crowding someone who had become distressed and another member of staff standing over someone putting their hands on either side of the person's armchair when the person had become distressed.

Staff and some relatives raised concerns with us about how staff were trained and supported to provide appropriate care. One relative told us, "I don't think there is enough training. They don't seem to understand Alzheimer's or dementia". One member of staff who raised concerns with us about staff training told us, "You need well trained staff for these kinds of people". Another member of staff told us, "If you are new to the job, you don't know when to back away and come back [to provide care]". Staff were not supported to understand how to support people living with dementia when they became distressed, identifying changes in needs and supporting people to eat and drink well. We observed staff not responding to distress, not supervising people to keep them safe and not meeting people's care needs.

These shortfalls were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training on some areas relevant to their role including first aid, MCA, care certificate, moving and handling and safeguarding. Two permanent clinical staff and one care worker had attended additional training to support their clinical practice around wound care and other staff had attended training on dysphagia. However there were no competency assessments or observations on file to assess if staff required additional support or training for three members of staff new to working in care. Five out of eight staff had not attended refresher training and regular supervision. Staff gave us mixed feedback about how supported they felt.

People were not effectively supported to ensure they had enough to drink and identify changes to meet their needs. When low amounts had been drunk by a person no action had been taken. Staff told us concerns about people not drinking enough were discussed at handover meetings in the morning. Handover records were not detailed and did not handover how much fluid people had drunk the previous day. Another relative told us about someone who required total support from staff to eat and drink, "Staff do not go in to remind [them] to drink". One member of staff told us people who walked a lot around the home were not drinking enough fluid. People were not receiving adequate support to have enough to drink. We saw people being left with drinks in bed who had been accessed as requiring support. For two people this meant that their drink had been spilt over them. We raised our concerns with the registered manager during the inspection.

The home had started recording the amount of fluids people were drinking and not just offered, in the previous week. We looked at the fluid charts for five people and saw there were gaps in recording, records were not always legible and staff were not clear how much fluid people had across a day. For example, for one person who was identified at being at risk of dehydration their fluid monitoring over six days recorded low amounts of fluids taken, including 130mls on one day and 200mls on another day. For another person there were no records of fluids offered or taken since the morning when we looked at their chart in the afternoon. A senior member of staff said, "It must have not been recorded" but they were not sure as they had not observed the person being supported to drink.

People did not have access to drinks in between arranged refreshment rounds. We observed that when

people sat in the lounge there were no drinks sitting beside them to have a drink outside of these times. We observed people being offered drinks and supported at set times, such as late morning, lunch and afternoon by staff.

Food and drink were not appropriately spaced, and meal time experience was in need of improvement. We observed people eating crisps, biscuits and fortified smoothies at 12pm before lunch was served at 12.30pm. One member of staff told us they felt theses snacks and smoothies were served too close to lunch. They told us that resulted in people at times having "no appetite for lunch". A healthcare professional told us meal times can be loud with loud 'pop music' and busy and the home only used one dining room on each floor. They thought this made it stressful for people living with dementia. We did not observe loud pop music being played in dining rooms during the course of our inspection. We observed people sat at tables or walking around the dining area for 30 minutes prior to their meal being served. There was 1950's music playing and people and staff were singing along. Most staff had a friendly and relaxed way of communicating with people and this meant most people laughed, smiled and responded positively to them.

People who were identified as nutritionally at risk were having fortified smoothies, prescribed fortified drinks and their food intake was monitored. One healthcare professional told us weights were being monitored and shared with them appropriately. However not everyone at risk of poor nutrition living at the home was receiving adequate support. For example, one person had lost over 2kg in six weeks and did not have a nutritional care plan in place. A member of staff told us, "He has a normal diet" and their weight loss was not being monitored each month. A healthcare professional told us they did not feel confident the home understood the risks of weight loss for this person due to their high levels of physical activity. The kitchen staff told us they prepared finger foods for one person who liked to walk and who was at risk of poor nutrition. This person had gained weight. For three other people at risk of weight loss who liked to walk throughout their day, they had lost weight. Two of these people were receiving prescribed supplements and the other person a healthcare professional had asked the service to put a nutritional care plan in place.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed during lunchtime most staff supported people at a relaxed pace to eat giving them time to finish their mouthful before they were offered the next mouthful. However we also saw staff standing up over people when they were assisting people to eat their meal or have a drink rather than sitting next to them. We observed the majority of staff explaining to people what they were eating and gave them choices of drinks and food off their plates. One healthcare professional spoke positively about how a member of staff had supported someone to have a drink and snack. We observed another member of staff bring people some ice creams which they looked to be enjoying. Staff were also seen assisting them to eat these ice creams.

People were supported to access healthcare services when needed. People were referred to healthcare professionals when needed including, the GP, tissue viability nurses and mental health professionals. Healthcare professionals felt confident in the clinical staff's judgements and referrals made. One health care professional told us, "They will ring to seek guidance". Another healthcare professional told us they were notified straightaway of any concerns, staff were very caring and staff always know they are coming.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. Some staff were kind, caring and positive. People and relatives spoke highly about some staff. Comments included, "[the member of staff] is absolutely brilliant", "there is a nucleus here of good staff" and "[two named members of staff] are magic". Some staff had a friendly and relaxed way of communicating with people and this meant some people laughed, smiled and responded positively to them. We saw some staff spending individual time with people playing cards and talking to people. We also saw some staff comforting people at times and people looked visibly comforted and content with this physical contact. However, our observations showed that not all people were treated in a respectful way and care provided was task led. We observed staff referring to people as the "walkers" and staff not talking to people before assisting them.

People's personal care needs were not always met. Healthcare professionals raised concerns with us about their observations of people not having their personal care needs met. We also observed that people had not had all of their personal care needs met. and raised our concerns with the registered manager as some people looked like their personal hygiene had not been met and there were gaps in records. For example, one person had dirty nails, spilt drink over them in the morning and food on their body and in their seat one and a half hours after lunch. . We saw other people had not been supported promptly with continence care and personal hygiene. Relatives also raised concerns with us that people had not received adequate personal care, including not been shaved, had a bath or shower. There were gaps in records or care provided.

Staff and health care professionals told us people were found walking around the home or in their rooms not fully dressed or their dignity protected. We also observed this during the inspection. People were not always supported to personalise their rooms with personal belongings and items that were important to them. One person's advocate raised concerns with us that the person's room did not include personal items from their home that were important to them. A health care professional raised concerns with the registered manager about another person's room that did not have any of their personal items. One relative told us people's rooms were not personalised because some people living with dementia went into other people's rooms and removed belongings. The provider told us following our inspection residents are encouraged to bring their possessions to personalise their room.

Relatives and staff told us that there had been a high turnover of staff at the home. This meant that people were cared for by staff they had not developed caring relationships with or had got to know. One relative raised concerns about this turnover. They said, "People with dementia need continuity". Relatives praised individual staff to us and said they were doing their best in "difficult circumstances". Another relative told us, "Staff change too often". The registered manager told us they were focusing on recruiting permanent staff and they requested the same temporary staff so there was continuity of care. The provider had also made arrangements to provide accommodation for some staff to encourage retention.

People were not always supported in line with their preferences. One person's care plan stated they preferred to get up before 9am; they liked their nails manicured and liked listening to music. They were

supported to get up at 11.30am and just before 12.00pm during the course of the inspection; the person was distressed during personal care and no music being played in their room. One member of staff told us, "[the person] sometimes sleeps through breakfast and so we don't wake them".

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their needs because information was not always handed over to staff. Assessments of people's needs had been completed for the majority of people and this information had been used to form people's care plans. Care plans contained information about people's assessed needs including some information about the actions staff needed to take to support people. However not all staff were able to describe people's care needs and preferences and care was task focused. Handover notes were brief and did not contain information for staff to follow to meet people's changing needs. For example, information about how much people had drunk in the last day and if there were any signs of distress or signs of pain that staff should be aware of. Not all staff had read people's care plans as they were new or temporary staff and had not had enough information handed over to them to ensure care provided met people's needs. Three staff told us that they had not had adequate information handed over to them to make them aware of how to meet people's needs. We raised our concerns with the registered manager and area manager who told us they would ensure that handover information was improved to all staff.

People's care plans lacked detail in order to guide staff how to support people who became distressed during care. For one person, their care plan lacked detail to guide staff how to meet their needs when distressed during care. Some staff told us they were not fully aware of this person's needs and how to support the person before they started providing personal care. For another person who had lived at the service for six weeks the home had not completed an assessment of all of their needs. The person's relative told us the home had not as yet completed a "proper care plan". They told us a senior member of staff told them this was now going to happen, including making a referral to specialist nursing team but they did not know what the staff knew about their relative.

A healthcare professional raised concerns with the registered manager about how two people's needs were being met and advice not being followed. The concerns included staff not following the care plan to meet one person's need. This resulted in the person becoming very distressed when this could have been avoided, their dignity being compromised and poor practice being observed. The registered manager told us they had arranged a meeting with the healthcare professional to discuss their concerns. Staff did not always respond to people crying out or appearing in distress or uncomfortable. We asked staff to respond to two people who we heard were distressed or crying out.. One member of staff told us, "she often screams out". Another member of staff told us, "[the person] is fine" when we heard their distress when receiving personal care and they were "often like that". Another member of staff told us if the person becomes distressed that staff leave them and come back. This was not what we observed.

There were staff employed in the home to support people with their wellbeing and plan activities five days a week. Social opportunities were provided through both group and one to one activities that were meaningful to people. We observed group activities with some people choosing to take part. The activities included painting, singing and of talking about the news. We saw that people enjoyed taking part in these activities and staff engaged with them positively and in a relaxed way. We also observed some positive interactions of some staff spending time with people playing cards, painting nails in the sensory room and

reading and talking to people cared for in bed. Records of support given for social opportunities were recorded. The activities provided to three of the four people were personal to that person. However for another person the activities planned did not meet their social and wellbeing needs. We observed that people living on the ground floor were supported to go into the garden by staff. Some relatives raised concerns with us that people living on the first floor had not been supported to go out. We asked staff about another person who lived on the first floor who was not being supported to go out into the garden. They told us the person could not walk but would look at them being supported to go into the garden in a wheelchair.

Concerns and complaints were not always responded to appropriately. Relatives and healthcare professionals told us they had raised concerns with the clinical staff and registered manager. The majority of people told us they were not satisfied with the response to their complaints. Complaints made by relatives that we were made aware of had not all been recorded by the provider. Some relatives told us they felt their concerns were listened to by the registered manager but not always acted upon and they still felt concerned about the care provided. The concerns included the standards of care, staffing numbers in the home and staff knowledge to support people.

Inadequate

Is the service well-led?

Our findings

There was not an open and transparent culture at the home. There were mixed responses from staff as to whether they felt able to raise concerns with the registered manager and management team. Staff were not always confident that concerns would be acted on and a culture had developed of staff not always raising concerns. One member of staff told us they did not raise any concerns with the registered manager as, "they did not want to get sacked". Another member of staff told us, "There is a culture of not speaking out for fear of being sacked". Staff told us they focused on trying to do their best by people that lived at the service. Other staff told us concerns were shared with clinical staff and action was taken. One member of staff told us they did not feel confident their private information or concerns would be kept confidential. They said, "If anyone says anything, everyone knows about it". Another member of staff described the registered manager as "approachable" and would listen to them.

There were no systems in place to review the high number of incidents of staff being hit by service users to review if people received appropriate and safe care and to prevent injuries. There was a culture in the home of staff acceptance of being hit by people was part of the job. Comments from staff included, "I got hit and kicked this morning" and "I was kicked a couple of times. I did not report it". We observed staff being hit and scratched. Staff told us about recent incidents of being head butted, kicked and punched. These incidents were not always recorded in an accident or incident book or individual care records. Staff had not received training around positive behaviour support to keep themselves safe and meet people's needs. We raised these concerns with the registered manager. They told us that visiting healthcare professionals had also raised concerns about this and had offered to provide training and this had now been arranged.

The provider and registered manager had failed to notify CQC about serious incidents, development of a pressure sore of grade three or above and safeguarding allegations. This is a requirement of the provider's and registered manager's registration so that where needed, CQC can take follow-up action. There were five allegations of neglect in July 2017 that the registered manager had been made aware of but had not reported to the safeguarding authority or CQC. There were three other allegations of abuse that the local authority made us aware of that had not been reported to CQC by the provider. One person had pressure sores that had been graded as grade 3 or above. The specialist nurse visiting the home on the 11 October 2017 advised the home to report these pressure sores to CQC as required. These notifications were not received.

These shortfalls were a breach of Regulation 18- Care Quality Commission (Registration) Regulations 2009.

We received mixed feedback from relatives and some staff about how the service was managed. One relative said, "The manager and deputy have just the right approach". One person told us the registered manager did not "walk around" the home and was rarely there. Another relative said, "I rarely see [the registered manager]. One third of staff raised concerns with us about how the service was managed. One member of staff said, "I don't think the service is well led" and that the "[registered] manager is hardly here".

There was a lack of adequate systems in place to ensure effective oversight over how staff were deployed to

ensure people's needs were met. We raised concerns with the registered manager about how staff had been deployed in the home to meet the needs of people with complex dementia care needs. The registered manager told us on the second day of inspection, "we had not looked properly at the skill mix" and "agency staff did not know what they were doing". It was the registered manager's responsibility to ensure the requirements of the regulations were met and staff had been deployed and inducted correctly. A relative told us, "Maybe this is something that could be addressed as if you have a manager who does not visit the floors every day to check on residents, they cannot possibly see the whole picture of what is required at the time. Another relative told us, "The agency staff are good and kind but don't know the ropes". We asked staff about gaps in records and two staff told us when agency staff were working, "records were poor". One temporary member of staff told us, "No one told me to complete any paperwork".

There was a lack of oversight and management of allegations of abuse at the home. The details of these allegations of abuse were not identified by the provider during visits to the home. Two relatives told us they did not feel that they were always told the full details of how people had sustained injuries.

People's records were not consistently completed so there was an accurate, contemporaneous record for people. Records were also not easy to find to allow easy access and review. For example, gaps in records in relation to thirty minute checks for people reliant on staff for care, fluid monitoring and safeguarding allegations. This meant the provider would not be able to review concerns effectively, or audit the care provided. There were also shortfalls in some records relating to the overall management of the service. This meant any learning or actions of how to improve the service and mitigate any risks such as from people's behaviour towards others were not identified and subsequently shared with staff. Other records, such as weight loss monitoring did not include everyone for reasons such as the person being accommodated on a temporary basis in the home. Handover information given to agency staff did not provide information about people's needs and how to best support them. Oversight over training records did not identify staff who were required to attend refresher training. Information displayed on notice boards had not been updated to detail accurately the date of someone's birthday and activities that day.

The governance systems in place were not effective in identifying all of the shortfalls we found during our inspection. Audits and checks did not identify where the service was not meeting the requirements of the regulations, such as adhering to DoLS conditions and the poor standards of care identified by CQC and other healthcare professionals. For example, audits of falls in the home were not consistently completed to identify any actions required. There were gaps in audits of wound care and infections. There were no audits of infections in the home since June 2017. There were no audits of wounds in September 2017 however the manager's monthly report in September 2017 stated there were no grade 3 or above pressure sores in the home. On the 21 September 2017 a nurse in the home identified a cavity wound and made a referral to a tissue viability nurse for specialist advice. This wound was later identified as upgradable. This meant that there was a risk that improvements required were not identified and changes made.

The provider improvement plan for the home recorded actions to be completed by February 2017 that were still outstanding. For example, ordering of a good quality camera for monitoring of wounds. A staff file audit in July 2017 identified that 18 members of staff in the home had not provided a full employment history as required. These actions were still outstanding.

The shortfalls in record keeping and governance were a breach of regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider wrote to us to provide assurance that additional resources had been identified for the home to start addressing the concerns in care provided handed over at the end of the inspection. Additional

resources identified include: support from provider's head of compliance, additional external training for staff to start with immediate affect following inspection and HR team to support area manager with recruitment and staff performance. The provider has said they will not take any new admissions until the "Home is safe". The nominated individual advised that they will instruct a review of all accidents and incidents over the past three months and identify actions, Dementia care mapping and review of people's needs and discussions with funders where necessary. They also said they would ensure there is more detailed written handover information and review feedback from relatives. The registered manager left the home as manager after the inspection and the home is now led by an interim manager. The interim manager is the regional manager who is full time at the home. The provider told us following the inspection about these arrangements.

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 Statutory notifications that were required by the Commission were not made. Regulation 18 (1) (2) (a) (e) of the Health and Social care Act 2008 (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not always acting in accordance with the Mental Capacity Act 2005. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to the health and safety of service users of receiving care and treatment were not fully assessed and mitigated. Medicines were not always managed safely. Regulation 12(1)(2)(a)(b)(g)

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 People were not protected by systems and processes that identified and investigated allegations of abuse. People's rights were not protected as authorised deprivation of liberty conditions were not met. Regulation 13 (1) (2) (3) (5) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of appropriately skilled staff deployed to meet people's needs. Regulation 18 (1) (2) (a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

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 17 HSCA RA Regulations 2014 Good governance The systems and processes in place to assess, monitor and improve the service were ineffective. The systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users were not effective. Accurate, complete and contemporaneous records were not being kept in respect of each service user. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

We imposed conditions on the provider's registration.