Delph House Ltd

# Delph House Limited

**Inspection report**

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## Ratings

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

## Overall summary

We inspected unannounced on 6 May 2015 and announced on 11 May 2015.

This was the first inspection of Delph House Limited under the provider's new registration. The Director and registered manager were the same as under the previous registration 'Delph House Care Home'. The last inspection of 'Delph House Care Home' under the previous registration was in April 2014 and we did not identify any shortfalls.

Delph House Limited is a nursing care home for 39 older people some of whom may be living with dementia in Broadstone, Poole. There were two shared bedrooms in use at the home. At the time of the inspection 36 people were living at the home and 23 of these people were receiving nursing care.

The registered manager has been in post at Delph House Limited and the previous registration since the service's registration in October 2010 under The Health and Social Care Act 2008. A registered manager is a person who has

# Summary of findings

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

At this inspection we identified serious shortfalls and breaches of the regulations. You can see the action we have asked the provider to take at the end of this report.

Where providers are not meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. You can see what action we have taken at the end of the report.

People's medicines were not safely managed, stored, recorded or administered. This was because some people did not have their medicines as prescribed and staff did not have clear instructions when they needed to give people 'as needed' medicines. Some medicines were not correctly stored or recorded. People's pain was not effectively managed and creams were not applied as prescribed. This placed some people at risk of harm and not receiving the treatment they needed.

Any risks to people's safety were not consistently assessed and managed to minimise risks. Their needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. People did not always receive the nursing care and treatment they needed and this placed them at risk of harm or neglect. Their health care needs were not always met because the healthcare support they needed was not delivered. People who were had vulnerable skin and or had lost weight and people who needed nursing treatment for bowel management were particularly at risk.

Prompt action was not taken when people lost weight and they did not all receive the fluids and food they needed to increase or maintain their weight.

Risks to people in the building were not always managed to keep people safe and some peoples' specialist chairs were not clean.

There were not enough nursing staff to meet people's care and treatment needs. Staff did not have all of the right skills and knowledge to be able to provide care and treatment to keep them safe.

People told us they felt safe and staff understood how to report any allegations of abuse. However, there was not an effective safeguarding investigation system in place to fully afford people protection. Staff did not fully understand the implications of the Mental Capacity act 2005.

The registered manager did not understand their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Applications had not been submitted for most of the people who this applied to and they were being unlawfully deprived of their liberty.

People knew how to complain but complaints were not always recorded.

The systems and culture of the home did not ensure the service was well-led. This was because people, relatives and staff were not routinely involved or consulted about the development of the home. The management of the home was reactive rather than proactive. When we identified shortfalls and risks to people they were addressed. However, the quality monitoring systems in place had not identified the shortfalls we found for people or driven improvement in the quality of care or service provided.

People and relatives spoke highly of the caring qualities of the staff and managers. We saw that staff treated people kindly and with respect.

Activities were provided and people had opportunities to be occupied.

# Summary of findings

The overall rating for this service is ‘Inadequate’ and the service is therefore in 'Special measures'.

The service 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.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

People were not kept safe at the home.

Risks to people were not managed to make sure they received the correct care and treatment they needed.

The management and administration of medicines was unsafe. People did not receive their medicines as prescribed and they were not stored safely.

There were not enough nursing staff to consistently meet people's nursing needs.

Safeguarding investigations were not thorough and did not consider all staff involved in safeguarding incidents.

Overall, staff were recruited safely but references had not been sought from previous care sector employers.

People were not protected by the prevention and control of infection and some risk areas in the building had not been managed.

**Is the service effective?**

Inadequate

People's needs were not effectively met.

Staff did not have the right skills and knowledge, training and support to meet people's needs.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act 2005.

Some people did not receive the food and drinks they needed to make sure their nutritional needs were met.

Some people did not receive appropriate nursing support to meet their skin care needs to ensure that they were comfortable and protected from harm. Most people were referred to specialist healthcare professionals when needed.

**Is the service caring?**

Good

The service was caring.

People and their relatives told us staff were kind and caring.

Staff respected people's privacy and dignity.

Staff had some understanding of people's preferences and how they liked to be cared for.

People and their relatives were involved in the planning of their care.

**Is the service responsive?**

Inadequate

The service was not responsive to people and their needs.

# Summary of findings

People did not always receive the nursing care they needed, their needs were not reassessed when these had changed and their care plans did not include sufficient information about their care and support needs. This meant staff did not have up to date information about how to care for people.

Information about complaints was displayed and people knew how to make a complaint. However, these were not all recorded.

**Is the service well-led?**

**Inadequate**

The home was not well-led.

The provider did not monitor the performance of the registered manager or the service to ensure people received a good quality service.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

# Delph House Limited

**Detailed findings**

## Background to this inspection

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

This inspection was unannounced on 6 May 2015 and announced on 11 May 2015.

The inspection team included two inspectors and a specialist advisor whose expertise was in nursing care of older people. We met and spoke with all 36 people living at the home. Because a small number of the people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six visiting relatives and with the registered manager, nursing deputy manager, floor manager (responsible for people with personal care needs) and eight staff. We also spoke with the provider in person during the inspection and by telephone following the inspection.

We looked at six people's care and support records, all 36 people's medication administration records and other documents about how the service was managed. These included staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of. We also contacted one local commissioner and the local authority safeguarding team. Following the inspection we contacted three healthcare professionals involved with people to obtain their views.

Following the inspection, the registered manager sent us information we asked for about policies and procedures, staff recruitment, and staff training.

Inadequate

# Is the service safe?

## Our findings

We looked at the medicines management systems in place at the home. The floor manager was responsible for the management of the medicines for people with personal care needs. The deputy manager and nursing staff were responsible for the management of medicines for people with nursing needs. We did not identify significant shortfalls with the management medicines for people with personal care needs. However, we identified a number of serious shortfalls in relation to the management of medicines for people with nursing needs.

Most people with nursing needs did not have 'as needed' PRN medicine plans in place on the first day of inspection. Nursing staff had put PRN plans in place by the second day of inspection but these did not give sufficient detail so staff knew the circumstances as to when they should administer medicines. For example, one person had been given PRN sedative medicines instead of the PRN pain relief that had been prescribed. The person's daily records included they had been upset and agitated because of pain. However, a sedative had been administered twice on the same day rather than the additional pain relief the GP had prescribed the previous week.

On the first day of inspection we found a pain assessment tool for people living with dementia in people's care plans. This tool was to assess people's pain levels if they could not verbalise if they were in pain. However, nursing staff were not using this tool when administering medicines to relieve people's pain. This meant people living with dementia may not have been having pain relief when they needed it. The deputy manager took action and put the assessment tool with people's medicines records. On the second day of inspection nursing staff had been using the pain assessment tool for people living with dementia. We found that people were now having pain relief on a more frequent basis than before the assessment tool was being used. This meant that before the second day of inspection people did not receive the pain relief they needed.

People's cream application records were not completed to show whether people had their creams applied as prescribed. For example, one person had visibly dry and scaly skin and the cream records showed that the cream had not been consistently applied twice a day to the person's dry skin as prescribed. This person told us their skin was itchy and, "I'm feeling more itchy than usual". We saw they were constantly rubbing their back and arms. We reported this to the deputy manager who applied some cream.

Some people had their medicines covertly; this meant the person was not aware they were taking medicines, for example in a drink or food. There was a 'covert medicines pathway' that considered whether the person had the capacity to make the decision, the best interest decision and the other people that needed to be involved and consulted in the decision making. This included the person's representatives, their GP and the pharmacist. However, the pharmacist had not been consulted about these decisions. This meant staff had not checked whether the medicines were safe to be crushed or given in food or drinks. The pharmacist had been consulted about these plans by the second day of inspection.

We looked at the medicines storage and found that some excess stock medicines were stored in kitchen type cupboards in communal areas that did not meet medicines safety standards. We also identified that one of the controlled drugs cupboards did not meet recommended standards. The deputy manager and floor manager took immediate action and ordered medicine storage that met recommended standards. We saw confirmation that these had been ordered on the second day of inspection.

We checked the controlled drugs storage, record keeping and management. Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines. They have to be stored differently to other medicines and a separate register must be kept. We found controlled drugs in the controlled drugs storage that were not recorded in the register for four weeks. We checked the medicines administration record MAR and found the amount of controlled drugs recorded differed by five. This meant that potentially five of these controlled drugs were missing. Nursing staff had audited the controlled drugs and register on 17 April 2015 but had not picked up that these controlled drugs were in the home. This was a breach of the Misuse of Drugs Act 1971 and The Misuse of Drugs Regulations 2001.

We asked the registered manager to investigate this serious shortfall in the management of controlled drugs. On the second day of inspection they were able to demonstrate

# Is the service safe?

that nursing staff had incorrectly written the amount of medicines received into the home. The registered manager told us they and the deputy manager had now audited the controlled drugs and the register was correct.

The floor manager and deputy manager told us they audited the medicines they were responsible for every month. However, the deputy manager and nursing staff had not identified any of the shortfalls in the medicines management for people with nursing needs. The registered manager did not check the audits to assess whether they were effective. This meant that because the managers were checking the systems they were each responsible for, the multiple shortfalls in the nursing medicines management had not been identified.

People had risk assessments and management plans in place for epilepsy, falls, moving and handling, pressure areas and nutrition. However, some risk assessments and management plans were not accurate or not followed by staff. For example, people's nutritional risk assessments were not accurately calculated when they lost weight. This meant that the risk assessments had not prompted any action to respond to people's weight loss. People's pressure area risk assessments were completed but the management plans put in place were not always followed by staff. This meant people did not receive the care and treatment they had been risk assessed as needing.

On the first day of inspection we identified at least four radiators in bedrooms that were not covered or that were cool touch radiators. Nor were there were not any risk management plans in place for the people living in those bedrooms to reduce the risks of scalding. The registered manager took immediate action and ordered radiators covers for these bedroom radiators.

At our last inspection in April 2014 under the provider's previous registration we identified the balustrade on the first floor landing was lower than modern standards and may present a risk to people. The registered manager had completed a risk assessment but had not put a risk management plan in place for any people who were independently mobile and may be at risk.

We did not specifically look at infection prevention and management during this inspection. However, the local authority and clinical commissioning group (CCG) had visited on 7 and 8 April 2015 and as part of their contract monitoring visit they looked at this area. They noted that overall this was managed well but that a number of people's specialist reclining chairs were ripped and one had food debris and staining down the side. At this inspection this person's chair still had food debris and staining down the side and some of the chairs had small tears. This meant that one chair had not been cleaned. We are unable to determine whether this was the same food debris and staining that had been there on 7 and 8 April 2015, when it was noted by the local authority and the others were not able to be effectively cleaned because of the small tears.

These shortfalls in the risk management, medicines management, ensuring the premises are safe and preventing and controlling the spread of infection were a breach of Regulation 12 (2) (a)(b)(d)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and relatives said there were enough staff most of the time. However, this contradicted what we found in relation to nursing staff numbers. The registered manager used a dependency tool and used this to calculate overall staffing numbers. They added an extra health care assistant to the calculation make sure people's personal care and support needs were met. The staffing numbers were sufficient to meet people's personal care needs but there was only one nurse on duty for 23 people with nursing needs. This meant that there were not enough nursing staff to meet people's nursing needs. This was supported by the shortfalls we identified in people's nursing care.

The nursing staff shortfalls were a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home. Relatives told they felt their family members were safe. A relative said, "I feel he is safe and I'd know if he wasn't happy".

Staff had been trained in safeguarding as part of their induction. All of the staff we spoke with were confident of the types of the abuse and how to report any allegations. We reviewed the safeguarding policy and found it had the incorrect telephone contact details for the local safeguarding authority on the front page of the document. This should be updated to include the correct contact details.

Inadequate

# Is the service safe?

The registered manager had not made notifications to CQC when allegations of abuse were made and investigated by the local authority. This meant we were reliant of information from the local authorities rather than the home as required by the regulations. There was not effective learning from safeguarding investigations. Staff told us they thought the registered manager told them about safeguarding investigations and the lessons learnt. However, none of the staff or managers were able to tell us about any practices that had changed as a result of recent safeguarding incidents at the home.

The local authority had asked the provider and registered manager to investigate a number of safeguarding allegations but the investigations did not fully consider all of the information available. For example, the registered manager was asked to fully investigate a safeguarding allegation but they did not consider the actions of all the staff involved and subsequently did not take any action with some staff members. This meant that people were not fully protected from potential harm.

The registered manager had also made some referrals to relevant professional bodies. For example, nursing staff had been referred to the NMC (Nursing and Midwifery Council) following medication errors and where staff had not fulfilled their responsibilities as a registered nurse. However, this was not consistently applied for all the nursing staff working at the home who had been involved in safeguarding incidents.

The shortfalls in the effective systems and processes for investigating allegations of abuse were a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four staff recruitment records and spoke with one member of staff about their recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people. This included up to date criminal record checks, fitness to work questionnaires, nursing registration numbers, proof of identity and right to work in the United Kingdom and references from appropriate sources, such as current or most recent employers. Staff had filled in application forms to demonstrate that they had relevant skills and experience and any gaps in their employment history were explained. This made sure that people were protected as far as possible from individuals who were known to be unsuitable. However, a reference had not been sought from one staff member's recent care sector employer. This meant the registered manager did not have full information about this persons conduct whilst working in a nursing home. This was an area for improvement.

There were emergency plans in place for the home and building maintenance. In addition to this there were weekly maintenance checks of the fire system and water temperatures. There were robust systems in place for the maintenance of the building and equipment.

Inadequate

# Is the service effective?

## Our findings

People told us the staff knew their needs and how to care for them. Staff had a good understanding of how to meet people's personal care needs. However, we identified shortfalls in the nursing care skills.

Staff completed core training, for example, infection control, moving and handling, safeguarding, fire safety, health and safety and food hygiene. Staff told us the induction training they received had been effective and that they had felt well supported throughout their induction period.

The registered manager told us there was not a training plan in place for staff but some target training dates were identified on the training record. Information from staff appraisals, safeguarding incidents or identified shortfalls was not used to develop a training plan or identify skills shortfalls. For example, wound management had been a theme of safeguarding incidents and the registered manager had not identified that nursing and care staff would benefit from more training in this area.

The shortfalls in the staff's skills and experience to provide safe care to people was breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a mixed response from staff and managers as to whether they felt supported. This was dependent on who their direct line manager was. Most staff we spoke with told us they had a one to one support meeting with their line manager and we saw records to support this. The staff records we looked at included an appraisal but this information did not feed into any training and development plan for the home.

People told us they were satisfied with the food at the home. People were given a choice of meals in the morning. People told us that if they didn't like the two choices the cook would make them something different.

We observed people were supported to eat and drink at meal times. Staff also supported to people to drink in between meals. However, we could not be sure that people were receiving all of the fluids they needed or that the records were accurate. This was because two staff told us they thought accurate amounts were not recorded because some fluids were given to people but were not always recorded. In addition to this nursing staff were reviewing the fluid amounts people were having each night to see whether they reached a target amount of fluids to keep them hydrated. Of the 21 people who were having their fluids monitored seven had not reached their target in 10 days. There were not any records of actions taken to in response to these people's low fluid intakes or what action was taken to increase these people's fluid intake.

On the first day of inspection the registered manager told us 16 people had been referred to the GP because they had lost weight the previous month. Some of these people had been losing weight over a longer period of time but action had not been taken to implement specific nutrition plans until after this GP referral. The plans in place did not follow the written guidance given on the service's nutritional assessment tools. For example, supplementary and milky drinks were not given between people's meals. Food monitoring records did not detail whether foods were fortified (e.g. added full fat cream, full fat milk with milk powder added, full fat cheese). However, the cook told us they were fortifying people's meals but this was not recorded on people's care records.

These shortfalls in meeting people's nutritional and hydration needs were a breach in Regulation 14 (4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive effective nursing care to meet some of their health needs. One person had a pressure sore on their heel. Their pressure area risk management assessment on 20 April 2015 identified the person's skin was intact. However, nine days later on 29 April 2015 the person had a necrotic left heel. There were no records during those nine days as to what had happened with the heel and what preventative action was taken. The person had been referred to the tissue viability nurse (skin specialist nurse) and the wound was managed from this point on. This person had also lost 10kg in weight over six months and this not been identified by staff as an area of concern. This meant no action was being taken to increase this person's nutritional intake.

Another person had a sore on their buttock. The person's risk management plan in place stated that the sore needed daily assessment. On the second day of inspection the wound had not been assessed for two days. The records included that on 4 April 2015 the wound had started bleeding but there was no photograph or comment on the

wound condition since. There was contradictory information in the person's records. One section of the care plan stated the wound was healed but the tissue viability nurse was contacted on 23 April 2015 and a report dated 10 May 2015 included the sacral area was bloody.

These shortfalls in accurately assessing, planning and meeting people's care and nursing needs were a breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, people were referred to healthcare professionals once healthcare issues had been identified. For example, people were referred to dieticians, physiotherapists, community psychiatric nurses and tissue viability nurses. However, the local authority, CCG and safeguarding team identified there had been a reliance on waiting for the GP's scheduled weekly visit to have people's health care needs assessed and met. The registered manager told us that since they had received this feedback they had informed all nursing staff that if people needed medical attention they should take action if the matter could not wait for the GP's routine weekly visit. We saw records that showed nursing staff were now calling for medical attention when needed.

We had feedback from a healthcare professional and they told us that once they were involved with people the staff responded well and followed their advice and guidance. They said the registered manager had purchased the appropriate specialist equipment for people to minimise the risk of further pressure damage. However, they also said they had some general concerns about the staff's skills in identifying pressure areas at early stages and taking action so they did not develop into pressure sores.

The registered manager did not fully understand their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). They were not fully aware of the implications of the supreme court judgement in 2014 and the circumstances when they needed to make an application. The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Some of the people living at the service had been assessed as lacking mental capacity due to them living with dementia. DoLS applications had not been completed and submitted to the local authority for the majority of people living at the home who were being deprived of their liberties. The registered manager was aware of the need to apply for these DoLS for people. This had been identified at our last inspection in April 2014 under the previous provider, during a safeguarding meeting March 2015 and again at the local authority and CCG contract monitoring visit in April 2015. This meant that people were being unlawfully deprived of their liberties.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We met and spoke with the one person who was subject to a DoLS authorisation and their relative; we reviewed their care plan and spoke with staff. Staff were aware and understood the implications of the restrictions in place for this person. Best interest decisions were recorded in relation to the restrictions, care and support in place. The relative we spoke with confirmed they and other relatives had been consulted and involved with the best interest decisions in place. However, there was a mixed understanding from some staff about the Mental Capacity Act 2005 (MCA) and the presumption that people have capacity to make decisions for themselves. There was not a consistent approach to making specific best interest decisions when people had been assessed as not having the mental capacity to make a decision. For example, one person, who the registered manager had applied for DoLS authorisation because they did not have the capacity to consent to remaining at the home, did not have any capacity assessments or best interest decisions recorded in their care plan.

The staff's lack of awareness of the principles of the Mental Capacity Act 2005 and the lack of mental capacity assessments and best interest decisions was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

# Is the service caring?

## Our findings

People and relatives were positive about the care provided by the staff. One person said, “The carers are really lovely” and a relative said, “The care is second to none”.

On the first day of the inspection, information about four people’s personal preferences of care workers was displayed on their bedroom doors. We raised this with the registered manager because displaying this information this did not respect people’s privacy and dignity. The floor manager immediately removed this information and told us they would ensure that all staff and agency staff received people’s personal preferences at handover.

People told us and we saw that overall staff respected people’s privacy and maintained their dignity. One person said, “They’re always very nice and they always knock before they come in”. Staff used privacy screens when moving people in the lounges to maintain their dignity. The registered manager told us the local authority and CCG contract monitoring team had recommended these screens be purchase following their visit in April 2015.

We saw staff supported people in a sensitive and caring way. They did not rush people and chatted with them. Staff had an understanding of people’s personal preferences and the way they liked to be cared for. For example, staff phrased questions in ways the person could answer.

People’s wishes were respected. For example one person chose to have a stair gate across their bedroom door to prevent other people entering their bedroom whilst they were in there.

Staff smiled and they were relaxed and friendly, they were kind and they treated people with patience and respect. They spoke fondly about people and told us they enjoyed the time they were able to spend with people.

People and relatives told us they were supported to maintain their relationships. Visitors told us they were made to feel welcome and could visit whenever they wanted to. One relative said, “I’ve found everybody very willing to help”.

Inadequate

# Is the service responsive?

## Our findings

People told us staff responded when they wanted any help or support. One person said, "Staff come quickly when called". However, this was not consistent because on both days of the inspection one person was calling out repeatedly. We asked the registered manager about this and they told us it was because the person wanted a DVD or the TV putting on. The registered manager put the DVD on and the person stopped calling out.

People's needs were assessed prior to their admission to the home. However, this information was not consistently used to develop a plan of care particularly for those people with nursing needs. For example, one person's assessment identified their top set of teeth had been lost in hospital before their admission. No action had been taken to refer this person to a dentist, there was no plan of how staff were to manage their mouth and denture care and the lack of a top set of dentures had not been considered a contributing factor to this person's lack of nutritional intake and subsequent weight loss.

In the main care plans covered the majority of people's needs and were personalised. People and relatives told us they had been involved in developing their care plans. However, some nursing care plans were not accurate or consistently reviewed and updated to reflect people's needs. Some care plans included contradictory information. For example, one person's plan had been reviewed by a nurse the night before the second day of inspection. The person's review of their skin was not accurate. We saw the person's skin was dry, their skin was very thin and they had a dressing on their left arm from a skin tear. The person told us their skin was itchy and was scratching their arms, back and face. The care plan review stated the person's skin was intact and there was not a body map or record of any action taken in response to the skin tear. This person's skin risk assessment and plan did not take into account their significant weight loss and low food and fluid intake or consider how this contributed to their risks to their skin. In addition to this their care plan identified they had lost weight but did not detail what action was needed to address this. Food and fluid records did not show the person had been given any fortified foods or non prescribed nutritionally supplementary drinks to increase their weight.

Another person's care plan was not clear about how they communicated and the impact this had on their well-being. The person was living with dementia and their communication care plan included that when the person was confused their 'speech was unintelligible'. This contradicted their person's medicines plan that included 'XXX is able to say if they are in pain'. This person had a chronic painful health condition. We spoke with the person and their relative. The person told us they did not have any pain but their relative told us and we saw that if the person moved their leg they winced with pain. Staff told us the GP was reducing this person's pain relief and that the person often refused PRN pain relief. However, there was no plan in place to reflect how this change in pain relief was being managed and how they were ensuring that this did not leave the person in pain. This meant the person's pain was not managed. By the second day of the inspection staff had been using a pain assessment tool and we saw the person was having pain relief on a more frequent basis.

There was institutional practice in place in relation to people's bowel management and monitoring. This resulted in people not receiving the care and medicines they needed to alleviate constipation. There was a communal record of people's bowel movements. The registered manager told us this was the most effective way for nursing staff to monitor whether people needed any medicines they had been prescribed. However, we found five people had gone five days between bowel movements and they had not been administered the medicines prescribed to alleviate their constipation. People's care and PRN medicine plans did not include sufficient detail so staff knew when to administer these medicines. For example, one person's bowel care plan did not specify how many days to wait between bowel movements before taking action. This meant this person did not receive their PRN medicines to relieve their constipation.

Nursing staff had not consistently responded to people's healthcare and nursing needs. For example they had not linked or considered requesting a review of one person's International Normalised Ratio (INR) who was on warfarin when they had a bleeding wound. INR is the measure of a person's blood clotting.

These shortfalls in accurately assessing, planning and meeting people's care and nursing needs were a breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service responsive?

There was an activities co-ordinator who worked Tuesday to Saturday each week. People told us and we saw they enjoyed the activities on offer. One person said, "I really like the quizzes it keeps my mind active". The activities worker spent time with people who were cared for or stayed in their bedrooms every morning. There was a timetable of activities displayed in the main foyer of the home and we saw staff let people know what activities were on offer. Some of the activities included were: pamper sessions, book club, newspaper reviews, and arts and crafts, flower arranging, and Tai Chi, karaoke, bingo, exercise and cinema club.

People and relatives told us they knew how to complain. One person said, "I've never had any complaints". However, one relative had contacted us prior to this inspection to raise concerns. We suggested they make a formal complaint and we would follow this up at this inspection. The registered manager told us this relative had complained and that everything was now resolved. There was not any record of the relative's complaint or their meeting with the provider. This meant the provider and registered manager had not followed or recorded the complaint in line with their own complaints procedure.

The shortfalls in operating an effective complaints system was a breach of Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

Our findings throughout the inspection were that the registered manager was reactive rather than proactive. None of the monitoring or audits systems in place had identified the serious shortfalls we found. However, the registered manager and provider did not always consistently take action when shortfalls were identified by other professionals. For example, at a safeguarding meeting in March 2015 it was identified that the registered manager needed to make DoLS applications for people at the home. This was raised again by the local authority and CCG when they visited in April 2015. However, all of the applications still had not been made when we inspected in May 2015.

The provider did not check whether the systems the registered manager had in place were effective. This meant the provider was not aware of the shortfalls in the safety, health and welfare of people and the governance of the home.

There were numerous audits being completed by the nursing staff, deputy and floor manager. Some of these included audits of wounds, care plans, medicines, infection control, mattress and bed rails checks, daily fluid monitoring and call bell checks. However, these were not all consistently completed or undertaking at the frequency specified on the documents. Actions were not recorded when shortfalls were identified.

The registered manager told us that none of the audits, monitoring systems or feedback from people, staff and relatives were used to identify actions needed. They told us there was not any overall improvement plan for the service. They did not have any systems in place for using the shortfalls identified to improve and develop the service. This was supported by our findings.

The registered manager did not keep themselves up to date with new guidance and good practice. For example, the registered manager was not aware of the Key Lines of Enquiries (KLOEs) that we use to ask the five questions about services. These were introduced in October 2014. They were also not aware of the new fundamental standards regulations (Health and Social Care Act 2008 (Registration Regulations) 2014) that came into force on 1 April 2015.

The registered manager told us they had resigned because they were retiring and would be cancelling their registration as manager. The provider told us they had advertised for a new manager and following the inspection they had increased the nursing hours by 20 hours each week.

Staff raised that communication was not always effective but on the whole they were kept up to date about important things during handovers. Staff told us the registered manager infrequently attended handovers. Staff told us they had staff meeting and we saw records of these meetings. The deputy manager and floor manager told us they had an informal discussion about the management of the home with the registered manager over lunch when they were all working together. There were no formal management meetings that were recorded so the deputy and floor manager were kept updated about any actions required to improve the service.

The registered manager told us that staff were given information about their roles and responsibilities when they started work at the home. However, they said they had not clarified with staff who had worked at the home for a long time what their responsibilities were and these would have changed since they started work at the home. For example, the registered manager had not defined who was responsible for assessing and monitoring different elements of the service.

Surveys were completed bi-annually with people who lived at Delph House and bi-annually with relatives. It was not clear from discussion with the registered manager why this consultation was not conducted annually. The registered manager told us the activities coordinator had completed these with people in February 2015. However, the registered manager was not aware of the results or how they would use the information to improve services. The registered manager agreed to send us the results of these but at the time of writing the report these have not been received. The survey results and evaluation were sent to us following the production of the draft report.

There were infrequent meetings with people who lived at the home and these were facilitated by the registered manager and activities co-ordinator. The registered manager told us at the last meeting they had discussed

going on a day trip to Poole Quay. The registered manager said they did consult with relatives informally and they did periodically have relatives meetings. However, they had not held a relatives meeting in 2015.

Records were not accurately maintained and each person did not have a contemporaneous record of the nursing and personal care and support provided. We found shortfalls in food and fluid, care plans, medicines and wound records. Handover records were not all dated and the use of communal records meant there was not a complete record for each person.

The shortfalls in the governance, management of risks, record keeping, acting on feedback from relevant persons and the lack of improvement planning were a breach of Regulation 17 (1)(2)(a)(b)(c)(e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had notified us about some significant events but they had not submitted any for people who were subject to DoLS, safeguarding incidents or for the person who had developed a grade 4 pressure sore on their heel.

The lack of notifications from the registered person was a breach of Regulations 18 (2)(a)(b) (e)(4)(4A)(a)(b) of the Care Quality Commission (Registration) Regulations 2009

People, staff and relatives we spoke with told us the registered manager was very approachable, friendly and likeable and listened to any concerns they had. Staff told us the home was a good place to work and there was a friendly and relaxed atmosphere at the home.

Staff knew how to raise concerns and were knowledgeable about the process of whistleblowing. There were policies about whistleblowing available for staff.

The registered manager told us about some recent improvements they had made. This included purchasing new specialist mattresses on the advice of the tissue viability nurse. They had also introduced a file for each person that contained all of their monitoring records. This file was kept with the person at all times in an effort to improve record keeping for people. This was introduced following the local authority and CCG contract monitoring visit.

The manager kept any compliments or thank you cards to show staff. However, these were not dated to be able tell what time period they related to. The two cards we saw were very positive about the care provided to people.

There was a suggestions box in the main foyer for people to leave any comments. It was not clear how the registered manager used this information to inform any changes.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>There were shortfalls in: risk management, the staff's skills and experience to provide safe care, ensuring the premises are safe and preventing and controlling the spread of infection |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>There were insufficient nursing staff to meet people's care and treatment needs. |

| 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<br><br>There were shortfalls in the effective systems and processes for investigating allegations of abuse.<br><br>People were deprived of their liberty without lawful authority. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs<br><br>People's nutritional and hydration needs were not being met. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>There was a lack of awareness of the principles of the Mental Capacity Act 2005 and a lack of mental capacity assessments and best interest decisions for some people. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>There were shortfalls in operating an effective complaints system. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>There were shortfalls in record keeping and acting on feedback from relevant persons. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>The registered person had not notified us of all incidents. |

This section is primarily information for the provider

# Enforcement actions

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

| 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 failed to take proper steps to ensure that care and treatment was provided in a safe way for each service user at Delph House Limited. The provider was not complying with the proper and safe management of medicines. |

**The enforcement action we took:**
We service a warning notice that the provider must comply with the Regulation by 14 August 2015.

| Regulated activity | Regulation |
|---|---|
| | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The provider was failing take proper steps to ensure that each service user at Delph House Limited received care and treatment that is appropriate, meets their needs, and reflects their preferences. We found evidence that the assessment of the needs for care and treatment of service users and the planning of their care or treatment to meet their needs were not consistently in place or did not accurately reflect their needs. |

**The enforcement action we took:**
We service a warning notice that the provider must comply with the Regulation by 14 August 2015.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider was failing take proper steps to assess, monitor and improve the quality and safety of the services. In addition the provider was failing to take proper steps assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. |

This section is primarily information for the provider

# Enforcement actions

**The enforcement action we took:**
We service a warning notice that the provider must comply with the Regulation by 14 August 2015.