HC-One Limited

Four Seasons

Inspection report

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21 January 2016

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on 20 and 21 January 2016. The home is a purpose built two storey building. Car parking is available at the front of the home. The home is close to local amenities and public transport. Four Seasons provides nursing and residential care including care for people living with dementia.

The home is registered to provide care and support for 121 people. The home is split into four areas known as houses. On the first day of our inspection there were 26 people living in Winter House, 15 living in Spring House, 27 living in Autumn House and 27 living in Summer House.

The home has a large reception area with appropriate information to inform people about the home and the services provided, including safeguarding and whistleblowing procedures. There is also a café (not staffed) with vending machines for drinks and snacks. There is access to the garden from the reception area.

The home had a registered manager at the time of the inspection. 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 and associated Regulations about how the service is run.

At our inspection in May 2015 we found three breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, good governance and person centred care. At this inspection, we noted breaches of Regulations 9, 12, 13, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that medication was not being administered in a safe and timely manner and that on occasions people had run out of their prescribed medicine. The provider had not taken reasonable steps to ensure people's care and support needs were being met. The provider had failed to ensure that people who used the service were protected from abuse and improper treatment. The nutritional and hydration needs of people were not being met. Systems or processes were not established and operated effectively to ensure compliance with the regulations and sufficient numbers of suitably qualified, competent, skilled persons were not deployed.

People who used the service were not cared for safely. Appropriate care was not provided and staff had failed to access timely professional advice. This placed the health and welfare of people at risk of harm.

We found there was conflicting and confusing information in the care records. Without clear and accurate records to monitor and manage potential health care risks to people it was not possible to know if people were receiving the care and support they required. Information was not always followed in accordance with the care plans and this potentially posed a risk of harm and poor care to some people who used the service. We found that charts that were important to people's health and wellbeing were incomplete.

Systems were not in place to prevent and control the risk of cross infection. People who used the service were potentially at risk from poor practice.

We found that staffing levels and skill mix at the home were insufficient. We observed people were left unobserved in the lounges for long periods of time. The home relied heavily on the use of agency nurses and care staff.

We looked at the staff training records. Staff training was on going, however due to some of the concerns raised it was evident that training was not embedded into the home to ensure good, safe quality care was being delivered. Staff confirmed that staff supervisions were ad-hoc and we found staff appraisals were inconsistent.

We found areas were locked and this restricted people's freedom of movement around their home.
The environment in places required cleaning and some en-suite bathrooms were cluttered and were being used to store equipment.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Following our inspection in May 2015, the home had been supported by the local authority and the clinical commissioning group (CCG). There was a restriction on placing any new people at the home. The local authority lifted their suspension in November 2015, the CCG suspension on nursing patients remained in place.

On the 21 January 2016, the inspection team had significant concerns for the safety of people who used the service and halted the inspection. We contacted the local authority and the CCG who attended the home and actions were put in place to ensure that people living at the home were protected.

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

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

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

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration.

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

inadequate for any of the five key questions it will no longer be in special measures.

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 safe.

The provider failed to ensure that the staff administering medicines were skilled and competent to administer and oversee the safe management of medication.

Staffing levels and the skill mix of staff did not safely support people's individual needs. .

Care was not delivered in a safe, caring and compassionate manner.

We saw that some people were at risk of significant harm as staff repeatedly failed to set special beds to the correct settings required.

People's health and wellbeing was compromised placing people at risk of significant harm.

People were not protected by the prevention and control of infection practices with the home.

Is the service effective?

Inadequate

The service was not effective.

People did not receive effective care based on good practice.

People were not supported to have sufficient to eat and drink to ensure their health needs were met.

Suitable arrangements were in place to assess where people were able to consent to their care and treatment. The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Inadequate

The service was not caring.

People's privacy and dignity was not promoted. We found one

person in a urine sodden incontinence pad which had leaked on to the mattress.

People with catheters and pressure wounds did not receive appropriate care. Some staff had received training in specialised areas such as catheter care. We found that staff had not implemented this training and some people were receiving unsafe care.

Is the service responsive?

Inadequate

The service was not responsive.

Appropriate care was not provided and placed people at risk of harm

There was a lack of stimulating and meaningful activities.

People knew who to complain to when required, but were not confident action would be taken.

Care records contained detailed information; however these were not always adhered to.

Is the service well-led?

Inadequate

The service was not well led.

Audits had been carried out however these were not sufficiently robust to pick up the issues we found in relation to medication, wound care and monitoring charts.

Relatives spoken with were concerned about the use of agency staff and the constant changes in management. There had been four managers appointed since 2014.

The service provided information about the home and facilities available.

Four Seasons

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.

This inspection took place on 20 and 21January 2016 and was unannounced. The inspection was carried out by: three adult social care inspectors; a pharmacist inspector; an enforcement inspector from the Care Quality Commission (CQC); and a specialist practitioner advisor (SPA). A SPA is a person who accompanies the inspection team and has specialist knowledge in certain areas. The SPA at this inspection was a general practitioner.

Prior to the inspection we received a number of concerns from the Clinical Commissioning Group (CCG) regarding poor nursing practice and poor care. We were informed that there had been a number of medication errors and safeguarding referrals. At the time of our inspection we were aware there were police investigations taking place.

During the day we spoke with people who used the service, staff and relatives, the registered manager and the management team, the chef and two visiting healthcare professionals. We also liaised with Bolton adult services commissioning team, the assistant director for Bolton children and adult service and staff from the CCG.

Over the two days we looked at the records including: the medication administration record sheets (MARs) and the medication for 24 people, care records for eight people, monitoring charts for food and fluid intake, records of weights and positioning charts, staff supervisions and staff training, records of staffing and relatives' meetings, policies and procedures and audits.

We looked around the home, observed lunch being served and looked to see how staff supported people who needed assistance with eating and drinking. We observed how staff interacted with people and how staff completed their daily tasks.

Inadequate

Is the service safe?

Our findings

One person we spoke with told us, "I feel very safe, never had to complain". Another said, "I don't think we are in a good place at the moment with what's going on. There are a lot of changes, let's hope things start to improve soon". We spoke with a relative who told us, "I am meant to be going away soon for a break; I am terrified of what's going to happen to [relative] whilst I am away". Another relative told us, "It's [the home] as bad as ever, we are back to square one" A third relative told us that, "All we want is good, safe care surely it's not too much to ask". Another relative said, "This situation cannot continue, the place has different managers all the time, the use of agency staff is still very high, the standard of care is not safe". One person told us, "If we were to move our [relative] it could be even more detrimental than staying here".

We visited the home with a pharmacist inspector from the Care Quality Commission (CQC) in September and in October 2014 and found that people were not protected against the risks associated with the unsafe use and management of medicines. We issued a Warning Notice to ensure that improvements were made quickly to ensure people were safe. The provider's action plan told us that systems had been reviewed and improved.

We visited the home with a pharmacist inspector (CQC) in January 2015 to check if improvements had been made in medicines management to ensure people were protected. We found that some improvements had been made. However we found insufficient progress had been made to protect people and we found that medicines were still not managed safely. We visited again in May 2015 and found further improvements in medicines handling. There was still improvement needed to embed practice and ensure sustainability, therefore we issued a recommendation for the management team to review national good practice guidance to support medicines optimisation at the home.

Prior to the inspection, we were informed, by the local authority safeguarding team and the home, of a number of serious medication errors that had taken place. A pharmacist inspector (CQC) visited the service on 20 and 21 January 2016 and looked at how medicines were managed for 24 of the 96 people living in the home. We found significant and serious concerns with regard to the safe and proper management of medicines for all 24 people whose medicines we looked at. We found the provider had failed to ensure that staff administering medicines were skilled and competent to administer and oversee the safe management of medication.

We saw that medicines were not managed safely. One person's medication was being given by method of 'secondary dispensing'. This is when medicines are removed from their labelled original boxes and placed in an unnamed pot and given to another member of staff to administer. This practice is deemed to be very unsafe because the medication could be given to the wrong person.

We saw there were systems in place to count how much medication was in the home for people. However the system was not effective because people still ran out of medicines. One person ran out of pain relief for five days. During that time they were in significant pain. The staff looking after this person failed to take action in advance of the medication running out and failed to order it in a timely manner. We saw another

person had run out of creams but the records were so poor it was not possible to tell how long they had not been able to have their creams applied. The systems for ordering medicines were poor and staff failed to take responsibility for ordering medicines.

We found that nurses and senior care staff who administered medicines failed to carefully follow the prescribers' directions, which meant people were not given their medicines safely. We saw one person had been prescribed a pain relief patch to alleviate very severe pain. The patch should have been changed every seven days; we saw it was changed late on a number of occasions which meant that person could have been in unnecessary pain, on one occasion for over 24 hours. When we compared the stock with the records we found that medicines were given but not signed for, or signed for and not given. This meant that sometimes people were not given their prescribed doses of medicines or people were given too much medication. We saw that one person had been prescribed treatment for Methicillin Resistant Staphylococcus Aureus (MRSA) but the treatment had not been given properly, which meant they were at risk of their infection remaining untreated. When the prescriber discontinued people's medication the staff failed to removed it from the medication trolley, which meant that it could be given in error.

We saw that the manufacturers' directions were not followed. Medicines, including antibiotics, which should have been given before food we often given with food, which means they may not work properly. We saw that nurses disregarded manufacturers' directions about how to use certain pain relieving patches which placed health at risk.

Most people in the home were prescribed medicines to be given 'when required' or as a 'variable dose'. We saw that there was either no information or insufficient information available to guide staff how to administer medicines prescribed in this way safely or consistently. If this information is missing especially for people with dementia medicines may not be given effectively or properly and people's health could be at risk. We saw that even when plans were in place they were not being followed. A carer told us that one person was routinely given medication to keep them calm each morning even though they may not need it.

One person who was prescribed a thickening agent to add to their drinks to make sure they could have drinks without choking did not always have their fluids thickened to the correct consistency. We saw other people were prescribed thickeners but there was no information for staff administering their medicines how to thicken their drinks. This placed them at risk of choking or developing a chest infection. No records about the use of prescribed thickener were made. It is important that accurate timely records are made to show that drinks have been thickened safely.

Some people needed to be given their medication covertly. This is when medicines are hidden in food or drink because people may refuse to take them and are unable to understand the harm this would do to their health. We saw that there was no information recorded to tell nurses that the medication should be given covertly or the safest most effective way of hiding the medicines. We saw that one person missed many doses of their medication because it was not given covertly. This placed their health at risk.

There was a homely remedy policy in the home so people could be given simple remedies such as Paracetamol for a headache. When we asked where the simple remedies were kept, the managers were unable to tell us which house they were on. When we located the homely remedies we found there was only one Paracetamol in the home. This meant that if people needed treatment for a simple headache they would not have been able to be treated speedily.

Many people in the home were prescribed creams. We saw that there was a lack of information available to guide staff where to apply the creams. We found that the carers failed to make any records when they had

applied creams to show people had had their prescribed creams applied properly. Some records were completed by nurses, however they had signed the record to indicate they had applied the cream when they had not done so and had no knowledge if the cream had been applied properly or at all.

Records about the administration of medicines were poor. We saw there were an unacceptable number of gaps on the recording sheets so it was impossible to tell if medicines had been given at all. We found on one unit the records were so poor it was impossible to tell if medicines had been given safely, the nurses in the house were aware but had not done anything to ensure medicines could be accounted for.

We saw that medicines were not always locked away during medication rounds. On both the days of our inspection visit we found the trolley unattended with medication left on the top of it. This is a risk because people could misuse the medicines. We had concerns regarding the safe storage of waste medication because it was not stored securely and arrangements for storage were not in line with the published National Institute for Health and Clinical Excellence (NICE) guidelines. If unwanted medicines are not stored securely they may be misused.

We were given a list of a significant number of medication errors which had been made over the past year. We found that there were more errors made than had been reported. We saw that errors were not investigated in a timely manner. When staff had made errors they were not properly supervised or retrained. This meant there was no timely or effective learning from the errors and there was little to prevent them being repeated.

We found this was breach of Regulation 12 (2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment

During our inspection, on Winter House we saw that the waste bin in the toilet near the dining room was broken with a sharp edge protruding, which was dangerous and could have caused a serious injury. There was also a broken bin in Spring House. We saw in one en-suite that this was cluttered and was being used for storage. This concern was highlighted at the last inspection in May 2015 about storing items in bathrooms.

Prior to the inspection we had been informed by the Infection Prevention and Control Team (IPCT) that two people had tested positive for MRSA. There were concerns that there was not a clear system for communicating people's infection status within the home. The ICPT had completed a training session with a number of staff at the home on 12 January 2016. During this training, a discussion was held about how to ensure people living at the service, who have a known infection such as MRSA have this condition appropriately communicated to all staff. This included agency nurses or care staff, or individuals deployed from other units during the day or night. It was decided to trial a 'yellow bee' system, printed and laminated, to display on a door/wall when entering the room. The significance of this sign should be communicated to all staff at home and would prompt the staff member to ascertain what infection this person may have, and if there were particular instructions for that individual.

On the 20 January 2016 there was no evidence of any 'yellow bees' on doors. This was discussed with the assistant operational manager who had no knowledge that this had been discussed and agreed. By mid-morning this had been actioned. One person whose relative should have had a yellow bee on their bedroom was not aware of this until it was mentioned to them by a member of the inspection team. This meant that clear communication about people's infection status was still not in place at the time of the inspection.

The ICPT team were told by staff that some people did not have their own wash bowls and the infection

control nurse provided two mixer bowls they had with them and requested that the home purchased individual wash mixer bowls. Staff informed the infection control nurse that there was also a lack of disposable gloves, aprons and continence wipes.

We contacted the infection control team following the inspection and informed them of our findings from the inspection. The ICPT visited the service on 26 January 2016 and identified a number of concerns relating to infection control practice. These had been identified on previous ICPT audits and had not been addressed. Examples of concerns included: lack of hand hygiene by staff unless directed when witnessed; lack of cleaning schedules, with the home being dirty in areas (such as sinks in en-suites, faeces on doors, and dusty, gritty floors). One air flow mattress when checked was found to have a worn cover, it was wet inside and extremely stained. A member of staff was seen feeding a person with MRSA wearing a material apron and wearing false nails. They did not change their apron, wash their hands or clean the trolley which was used for transporting the food after leaving this person's room.

We found this to be a breach of Regulation 12 (2) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

At our previous inspection, in May 2015 we found the home was not staffed according to the needs of people using the service. Following the inspection in May 2015, the provider put in place an action plan, which included reviewing people's needs and moving some people to a different 'House' within the home. We were told the provider would continue with an ongoing recruitment programme for further permanent nurses. However, at this inspection, we found this has not been addressed and sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed, which placed people at risk.

We looked at staffing rotas and staffing levels. The care records we looked at contained a dependency tool. This is used to assess the level of a person's individual need and the number of staff required to safely support them. For example in Autumn House seven people had dependency score rated very high, 12 people were rated as high needs, five medium and two rated as low dependency. In Summer House 21 people were rated as having very high needs, three people were rated as high and only one person rated as medium. On Winter house 22 were scored as very high needs, three scored high and one person scored as medium. We were not provided with the full dependency tool for Spring House.

We found there continued to be a high reliance on agency nurses within the home. We observed on 21 January 2016, at 07.30am in Spring House that two agency staff had covered the night shift. No permanent member of the home's staff was working in Spring House. This meant that people were being cared for by staff they did not know or and who did not know them. No explanation was offered by the management as to why two agency staff were working together. A member of the home's staff was sent from another house to help the agency staff complete the necessary paperwork.

When the day shift arrived on Spring House we were told that the agency staff had not completed all the night tasks as required. We saw two care staff and the house manager were on duty for 15 people living with dementia. Four of these people required two members of staff to assist them with moving and handling and personal care. The unit manager was giving out medication, which went on till 10.30 am. This meant that some people would have to wait for assistance in getting up and dressed and being served breakfast. We also observed that the lounge area was left unattended for long periods of time. Staff told us that more staff were required to ensure that people received safe and effective care. Staff said sometimes they had not time to take breaks that they were entitled to.

On 21 January 2016 we saw that in Winter House three members of staff had been on night duty. There were

28 people living with dementia in Winter House. The senior in charge of the home was included in those numbers and confirmed they were not supernumerary. The senior was expected to oversee the running on the home and respond to any issues in the other houses. This meant at times in Winter house only two members of staff, one being agency staff were left on duty to provide care to people, some of whom needed two staff to assist.

Due to the staffing levels and the layout of Spring and Winter houses it was sometimes difficult for people to find assistance and help from staff. We noted long periods of time when staff were assisting in bedrooms providing personal care or dealing with other tasks where in the lounge and corridor areas no staff were visible.

On the evening of the 21 January we noted that four agency nurses were on duty. These nurses had some, but limited knowledge of people living at the home. There were no permanent nurses from the home rostered on shift that knew people. This was discussed with the management and the CQC did not leave the home until a HC-One nurse was brought from another of their homes. Therefore, whilst people's dependency had been considered, staff with suitable experience and knowledge of the people living at the home had not been deployed.

We found this to be a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing

Inadequate

Is the service effective?

Our findings

We visited the kitchen and spoke with the assistant chef. This was to check if they were aware of how to fortify food and drinks when it had been identified that people were losing weight. A discussion with the assistant chef showed they were very knowledgeable. They told us how they fortified food with various products such as cream, cheese and butter. We were told that 'smoothies' were also provided. It was explained to us that yoghurts and pots of custard were routinely sent onto the units each day for anybody who wanted them. We saw there were plenty of these food products in stock. A notice board in the kitchen identified the special diets required on each unit such as; pureed, fortified, diabetic and low fat.

On the 20 January 2016 we saw one person sleeping alone in a small lounge. We were told they were unwell. In the late morning staff confirmed the GP had been called. The 'Daily Statement of Wellbeing' record showed that this person was 'offered lunch at 12.30 but not touched, so placed in fridge'. The lunch was reheated and reoffered at 14.30 again refused. At 15.15 a member of the inspection team saw a congealed plate of cold food consisting of cheese and onion pie, steeped peas, red cabbage with gravy on top. The inspector removed the plate of food and presented this to the management team so they were aware of what had been offered and left in front of a person who was unwell. The inspector suggested to staff this person may be more comfortable in bed rather than leaning over in a chair. The advanced nurse practitioner visited this person and instructed that staff 'pushed food and fluids' and a diet and fluid chart commenced and that night staff were asked to obtain a urine sample.

On the 21 January 2016 at 08.15, the inspector asked for the food and fluid charts for the above person. The charts had not been completed since 17.00 on 20 January 2016. Therefore it was not possible to ascertain if this person had received any food or fluid for the last 15 ½ hours and no urine sample had been obtained. We also noted that the 'Daily Wellbeing' records were inaccurate with a page missing. We asked the house manager about this but they were not able to provide any information about why the charts had not been completed by the night shift or to say whether this person had been offered food and fluids.

We observed the breakfast being served in one of the houses. We noted an excessive amount of sugar being added to a person's cereals. When we asked the member of staff why they did this they responded "To build them up". This demonstrated inadequate staff knowledge regarding what constitutes a healthy diet.

We saw that another lady, who was extremely underweight, was sitting at the table and hardly touched her breakfast but was not offered any support or encouragement to eat. She was later offered a drink but received no further attention. We looked at the care plan for this person which stated; 'To continue encouragement to eat'. There was detailed information in the care plan for breakfast, lunch and dinner, eating and drinking and instruction to contact GP to review if further weight loss was sustained and to refer to dietician. The daily food and fluid charts were seen and there was little evidence of any fortified or high calorie food given, there were long gaps between the supper and breakfast, on some occasions up to 16 hours. Occasionally this person had refused main meals, and had no alternative offered. Although the information in the care plan was good, there was no appropriate gap implementation and no personal support offered, which could potentially place this person's health at serious risk.

In one care record we looked at it stated 'Encourage to drink at least 1.5 litres of fluid per day and to calculate food/fluid targets and record intake. We reviewed the food and fluid charts and found that fluid intake was not consistently calculated. Some days indicated very low fluid intake without it being apparent that fluids had been encouraged. There were no notes to demonstrate what had been done in response to any low intake. We asked a member of staff could charts be stored anywhere else they us they were not aware of anywhere else where food or fluids would have been recorded.

For another person where concerns had been raised about weight loss, this person was on a list of people who were to be weighed weekly. We found no evidence of this taking place, this meant there was no record of weight loss or gain or any actions taken.

We found this to be a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Meeting nutritional and hydration needs.

We looked at the supervision tracker to ascertain the quality and frequency of staff supervision meetings. The tracker showed that staff were receiving between none and three supervisions per year (in 2015). We found that appraisals were inconsistent and at least four staff had received no supervisions in 2015. This was checked with the administration staff who could not find copies of any supervisions in certain staff files. For people who had received supervisions, we found notes were brief for example, 'works well in the team' and a brief summary of training planned or undertaken. It was not clear from receords held that there had been any meaningful discussion between staff and their supervisors. One member of staff told us, they received supervision three months ago, this was regarding paperwork and recording. They said, "With supervision they write a sheet out and you sign it, you don't sit down and discuss things every time".

We were provided with the staff training matrix. We saw that training was ongoing and included; medication training, safer people handling, equality and diversity, safeguarding, dementia care, health and safety, MCA and DoLS, infection control and nutrition and hydration. One member of staff told us, "There is too much e learning". Other staff spoken with confirmed that they had received training in MCA and DoLS and when prompted had a reasonable awareness of this meant.

We found training in certain areas had either not been undertaken by all staff, or had not been effective. For example, during the inspection, we found serious failing in the management of medicines. A number of staff that administered medication had not been assessed to ensure they were competent to administer medication safely. For catheter care, only 10 of the 19 people who required the training had completed this.

We found this to be a breach of Regulation 18 (2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing, in regards to staff receiving appropriate support, training, supervision and appraisal.

We found that the environment in houses where people were living with dementia was restrictive. People could not leave the houses as the doors were key padded and people were not able to move freely around the houses making good use of the space that should be available to them. Within the home, there are interlinking glass 'conservatory' corridors. During the inspection, these were closed off and were not being used. This meant that people did not have full access to the space available within the home and had limited places to move within the home.

We noted that the dining rooms were open and people had access to these areas. We asked a relative if the dining room doors were usual open and they responded, "No, are they allowed in there when it's not meal times?".

We saw that there was some signage to help people orientate around Spring and Winter houses. We saw that some people had their names and photograph on their doors to aid recognition of their rooms, however this was not in place for everyone.

We found this to be a breach of Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 –Premises and equipment, with regards to the premises being suitable for the purpose for which they are being used.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that the registered manager had submitted DoLS applications to the local authority as required.
We asked staff about DoLS, they had a list of people who were subject to a DoLS and who had applied for it. Staff were not clear in their understanding of what it meant but gave examples of someone being restricted and not being able to leave the home without being accompanied, and if a lap belt was used. A senior member of staff spoken with told us that, "Mental capacity assessments are usually done by the nurse who writes the care plans, who sees the residents day in and day out, when the care plan changes the capacity assessments are updated". They went on to say, "Training is received in house –it's e learning (training courses on the computer), there's no face to face or facilitated training. I had repeatedly asked for face to face development for myself, I am not a mental health nurse. All the nursing staff and the manager need training."

Inadequate

Is the service caring?

Our findings

We had been made aware by the CCG and through notifications received from the home, of continued poor care practice, some of which placed people at harm or significant risk of harm. For example, there was a serious incident relating to the lack of competence of an agency nurse. We had also been made aware of staff 'drag' lifting people when moving them. This is an out of date technique for moving and lifting people. This resulted in a person being bruised. These incidents had been reported the local authority safeguarding team and to the police.

Whilst walking around Summer Unit we were invited into a person's room by a relative at 12:40 hours. We were told that their relative, "needs changing" and they pulled back the bedcovers to show us the soiled sheet. We looked at this person's position change form. It documented that the person was to have their position changed two hourly. There was no record of the person having and personal care or their position changed since 07:17 that morning; an interval of over five hours. The relative told us they had been at the home since 09:30 hours and that staff had not been in to attend to their relative whilst they were there.

Inspection of the person's care plan showed they had previously had a pressure ulcer and remained at very high risk of further developing pressure ulcers. The care plan detailed the care and support required to prevent pressure ulcers developing. One of the requirements was to reposition the person two to four hourly. Failing to reposition, and provide personal care as required placed the health and safety of the person at risk of harm. The lack of care provided meant the provider had significantly disregarded the person's needs.

We found this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safeguarding.

One person spoken with told us their relative had recently been moved into another of the houses. They told us, "Care is very good and better on here. Happy with [relative] here. Always staff around which wasn't always the case on the other unit". A person who used the service (mainly self-caring) told us. "Yes, looked after quite well. Staff are reasonably good. A relative spoken with told us, "All we want is good, safe care it that really too much to ask?".

Visitors spoken with told us there were no restrictions on visiting times and some people stayed to assist feed their relatives at meal times as was their choice.

We saw that people were not always treated with dignity and respect. At lunch time we observed a member of staff approaching a person living with dementia from the rear and put a clothes protector on them. There was no interaction with this person and no discussion took place or reasons offered for the use of the protector.

We were informed by two people that their relatives were often the last to be attended to as their relatives' rooms were at the end of the corridor. One said, "They [staff] start at the top end of the corridor and work

their way down regardless of whether people at the bottom of the corridor need assistance". This meant that some people did not receive their care in a timely manner and this was done to meet staff needs and not the needs of people who used the service.

We asked a member of staff what they thought of the care being delivered they replied, "No, I wouldn't put my mum in here". Another member of staff said that things had slightly improved since the arrival of a new member of the management team. They went on to say, "Never spoken to the registered manager about care practices or care delivery. No discussions about care practice".

We saw for one person that their cultural needs had been considered and that common phrases had been translated into the person's first language. There was a clear directive in the care plan related to religious needs. We observed that there was a tape of the Koran playing in the service user's room. This meant that this person's religious and cultural needs were being respected.

We observed some staff interactions with people and these were kind. However, there was little time for staff to engage with people and to sit and chat with them. One member of staff told us they found they had to rush round to get their duties done and did not have time to see to basic care tasks.

We saw that people in the main were suitably dressed and wore appropriate clothing. On the 20 January in Spring and Winter houses we saw that not all people had socks/stockings or slippers on. We asked a member of staff about this and were told for one person they did not like socks or slippers on and preferred to walk around without them. We saw this was documented in this person's care file. The member of staff told us for another person without socks, "It is difficult to get his socks on and many people have no socks in their drawers and we need to get them dressed quickly". On the 21 January 2016 we found that most people had socks and slippers on.

We spoke with two visiting healthcare professionals. Both had ongoing concerns with the care for example, staff did not know how to reset bed settings despite being shown this on numerous occasions, gaps in recording, inappropriate use of equipment and not enough staff.

We asked one of the registered nurses in Summer house if they had received any training in end of life care. They told us they had undertaken specialist end of life training in 2010 and had also attended a recent refresher course in relation to the use of syringe drivers. Syringe drivers are used for delivering pain relief medications under the skin, usually over 24 hours; often used when other routes of administration are not suitable. From the training records provided during our inspection it indicated that in total three people had received training in the use of syringe drivers.

We asked the registered nurse if training in end of life care was available for other staff members. We were told, "I assume there is". There was no evidence on the training record provided that showed any member of staff had undertaken end of life training and the administration staff spoken with told us there was no end of life training on the system.

Inadequate

Is the service responsive?

Our findings

We looked at the care records of three people who were living on Summer Unit. We looked at their care plans, their positional change monitoring charts and one personal hygiene monitoring chart. A care plan details the individual care and support needs that a person may have and shows how those needs are to be met by the staff. Positional change and personal hygiene monitoring charts help to show if people are receiving the care and support required.

We also checked how the three people were being cared for by visiting them in their bedrooms. This was to check on their welfare and see if the care prescribed was actually being delivered.
We had received information of concern from the Bolton Clinical Commissioning Group (CCG) about the care being provided to one of the people on Summer Unit. The concern raised from the CCG was in relation to the fact the person had a pressure ulcer that had deteriorated in a short time and that inappropriate care was being provided.

In view of this concern we inspected this person's care record in relation to their pressure ulcers.
We found there was a pressure ulcer risk assessment in place dated from October 2015 that identified the person was consistently at very high risk of pressure ulcer damage. The risk assessment had been reviewed monthly as required. A review is when a care record or risk assessment is checked regularly by staff so that any change in a person's needs can be identified and the appropriate action taken where necessary.

We saw there was a pressure ulcer prevention care plan in place, dated from April 2015. This was reviewed monthly. This care plan detailed the care and support required to prevent pressure ulcers developing. One of the requirements was to reposition the person two hourly whilst in bed. Inspection of their position change form monitoring chart, from the six days leading up to the second inspection day, showed that the person had not always been repositioned two hourly. The form showed there were 15 occasions when the intervals between repositioning were from three to four and half hours. Failing to reposition and relieve pressure as required placed the health and welfare of the person at risk of harm. Appropriate care was not provided and did not meet their needs.

We found this was a breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person centred care.

Inspection of the care records showed that despite a pressure ulcer being identified on two previous occasions, May and October 2015, the records did not accurately and consistently record the progress or otherwise of the ulcers. It was recorded that two pressure ulcers were evident on 26 December 2015 and a specific wound dressing was to be applied every two days or when needed. We saw the pressure ulcers were dressed regularly up to the 02 January 2016. There was no evidence to show that they were re-dressed until seven days later; this was not in accordance with the care prescribed.

We found there was conflicting and confusing information in the care records in relation to the condition of the two pressure ulcers. In view of the fact that there were two pressure ulcers, a wound care evaluation

form was put into place for each one. It was not always possible to ascertain from these care records which ulcer had improved and required a dressing and which did not. This was because staff did not always use the relevant wound care evaluation form to record their findings and treatment. Staff did not always record which pressure ulcer had been re-dressed. Records from 12 January 2016 stated that one of the pressure ulcers had healed; however four days later it was recorded that the pressure ulcer had deteriorated and was 'necrotic' (dead tissue). It was not clear from the records if there had been a sudden deterioration of this pressure ulcer or if the records referred to the other pressure ulcer that had not healed. Failing to maintain an accurate, complete record of the care and treatment provided placed the health and welfare of the person at risk of harm.

We found this was a breach of Regulation 17 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance, with regards to maintaining accurate records.

A discussion with a visiting professional around the care provided to this person identified that the dressing being applied to the pressure ulcer was not in accordance with the prescribed wound care formulary that the Bolton CCG required.

Despite one pressure ulcer being identified as 'necrotic' on 02 January 2016 records showed that a referral to the tissue viability nurse (a nurse specialist in wound care) was not made until 17 January 2016.

Failure to access timely professional advice placed the health and welfare of the person at risk of harm. We found this was a breach of Regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

We visited the person who used the service in their bedroom to see how they were being cared for. We saw they were asleep, looked clean and comfortable and were being cared for on a specialised pressure relieving mattress.

We visited another person in their bedroom to check if they were being cared for appropriately and safely. This person, due to their medical condition, was not able to have any food or drink by mouth. They were being fed artificially by means of a tube inserted into their stomach; this is called a percutaneous endoscopic gastrostomy (PEG) feed. This meant therefore that their mouth must be kept clean to prevent infection and aid comfort. There was no mouth cleaning equipment in the room. Inspection of their personal hygiene chart in relation to mouth care showed that from 14 January 2016 to the second day of inspection, a period of eight days, there was no record to show that mouth care had been given.

We saw that this person had excessive mucus secretions coming from their mouth. There was no suction machine in the room to aspirate the secretions. The secretions were draining onto a pad left under their chin. This placed the person at risk of harm as they could have aspirated the secretions into their airways; causing respiratory problems.

We inspected the site of the PEG to check if it was clean. We found that the site was oozing slight blood stained fluid and was in need of cleaning. There was no information on the personal hygiene chart to show that the PEG site had been cleaned that day. We discussed this with one of the senior care staff who told us that it was the responsibility of the care staff to clean around the site when washing the person. Failing to clean the PEG site could lead to infection and pain. This placed the health and welfare of the person at risk of harm. Appropriate care was not provided and did not meet their needs

We also noted that the person's urinary catheter drainage bag was lying flat within their bed, instead of

being left on a stand at the side of the bed to enable correct drainage. Incorrect positioning of a urine drainage bag could lead to urine backflow, causing pain and infection. This placed the health and welfare of the person at risk of harm. Appropriate care was not provided and did not meet their needs.

Inspection of the person's care plan showed they were consistently at very high risk of developing pressure ulcers. The care plan detailed the care and support required to prevent pressure ulcers developing. One of the requirements was to reposition the person two hourly. Failing to reposition and relieve pressure as required placed the health and safety of the person at risk of harm. Appropriate care was not provided and did not meet their needs.

We found there was a breach of Regulation 9(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person centred care.

We saw that activities were limited. On both days we saw that people had little or no stimulation and there was no time for staff to spend quality time with people apart from when providing personal care. For example the activity on Spring house on 20 January 2016 was 'Tea and Chat'. We saw no evidence of this happening. People were offered drinks but this was nothing out of ordinary. Most of the people living in Spring House were living with advanced dementia and would not have benefited from that activity. We observed in Winter House from 09.30 – 11.30 am that apart from the television people had no stimulation, there was no staff contact and no one spoke to people. One person was heard repeatedly saying the same words and was distressed. No staff attended to this person until 11.15 when the tea trolley was brought in and the staff member spoke to people. This meant that people living with dementia did not receive any staff interaction, stimulation and were left unattended in the lounge. We did see some people playing bingo and a karaoke session one afternoon and there was a short visit where some people brought in some animals for people to look at.

We looked to see how complaints were managed and responded to. The complaints log showed that 22 complaints had been received since April 2015. We looked at several complaints, which had been documented, acknowledged and investigated. Complaints had been received in relation to staffing and poor standards of care and welfare. Where shortfalls had been identified it appeared the service had been honest and accepted these and offered apologies. We saw one complaint had not been progressed. The registered manager told us this this was due to an on going police investigation.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager at the time of the inspection. 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 and associated Regulations about how the service is run.

Following our inspection in May 2015 we identified three beaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection in January 2016 we found in total six breaches of the regulations, three of which were identified at the inspection in May 2015. Despite the action plan provided by the provider on 29 May 2015 assuring us that the three breaches would be addressed it was apparent this had not happened . For example, we found that staffing levels were still an issue, that records and charts were incomplete and people were not receiving person centred care. This meant that people were not receiving safe and effective care.

There was an extensive range of audits completed covering aspects of the service such as health and safety, falls, care plans and key clinical indicators. However, we found that these had been ineffective in ensuring that care was safe, effective, caring and responsive. During the inspection we found widespread failings in the standard of care delivered, that had not been addressed through the provider's governance system.

Many identified actions, although follow-up was sometimes inconsistent in the documentation. The 'falls analysis' did not look at contributing factors to the individual falls. The falls meetings should be monthly according to the 'cornerstone' manual. No meetings were recorded for January 2016, December 2015 and July 2015. There was limited information to demonstrate what was discussed or how the information was used.

Audits had generally been undertaken as required, although walk-rounds were not documented consistently on a daily basis (or twice daily as the manual indicated was required). We found gaps in the daily walk rounds of up to three days. The last entry was recorded on the 16 January 2016, which was four days before the start of our inspection. It was noted that an odour was detected and [member of staff] to investigate. Although this was identified no actions were recorded.

It was not evident that staff meetings or audits of care plans had been undertaken as frequently as the 'cornerstone' manual indicated they should be. There were some repeated issues identified in the medicines audits such as gaps in MARS and insufficient stock being in place for day one of the medicines cycle. This suggests any actions identified had not been effective in mitigating risk. Other items in the audit failed. There was no recorded explanation for the reason a 'fail' was given or to what action had been taken. We saw from the training matrix that 48% of staff had received training in administration of topical creams, 52% in sae storage of medicines and 44% in correct procedures for administering medicines. Following our inspection the provider forwarded the most recent medication audit, these highlighted that medications were still not being safely administered.

From a discussion with a senior member of staff we were told that training needed to improve, that the service was reactive to incidents rather than being proactive. This person did not feel adequately empowered to lead on changes. Another member of staff told us, "There can be massive communication breakdowns between the nurses and the managers. You don't always get told when people's needs have changed when you return from leave".

We were provided with the staff training matrix. This showed us that there were significant gaps in staff training. For example 64% of staff had received training in safeguarding vulnerable adults, 71% in safer handling of people, despite the provider being aware of two incidents were people had been moved in an unsafe way. We saw that 52% had received training in nutrition and hydration and 69% in promoting healthy skin.

Not all staff had completed training in caring for people living with dementia despite the home having two dementia houses and that staff on occasion moved from house to house. This meant that some staff providing care in the dementia houses who had not received appropriate training.

We were told that the registered manager held daily 'flash meetings' (daily briefings). We found significant gaps of up to one week. For example none were recorded for 05 - 07 December 2015, 09 – 11 December 2015, 13- 14 December 2015, and 17- 23 December 2015, 25-29 December 2015. We noted that on the 09 January 2016 staffing levels in Spring house were discussed and on 13 January 2016 the records stated ' [member of staff] on own , behind with things', no further details of actions or support.

We looked at the staff meeting minutes; these should be monthly according to the 'cornerstone' manual. There were no meetings evident in October 2015 or December 2015. In January 2016 at the night staff meeting staff were asked if they knew how to set mattresses to the right setting, they replied 'No' and suggested that people who used the service reset them and staff did not know how to change them back. Frustrations were raised in relation to the use of agency staff. One member of staff said. 'Night staffing is dreadful and unsafe'. At the November meeting 2015, feedback given to staff in relation to concerns raised about staffing was documented as 'across the country there are benchmarks for staffing levels per resident' the records stated that dependencies were checked. Concerns raised by staff were in relation to staffing levels and impact on falls and documentation.

We found that the systems in place to enable effective assessment and monitoring of service provision in order to protect people from unsafe care and treatment were failing.

We found this was a breach of Regulation 17 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance

We were aware that relatives' meetings were held. The last meeting was held on 17 December 2015. Actions were discussed from the November 2015 meeting and topics included: a high level of concerns from relatives about staffing levels and supervision in the lounges. One person at the October 2015 meeting was recorded as saying, 'My [relative] has been here 18 months. I have never met with you [management], I am feeling desperate'.

We saw copies of relatives' opinions surveys/feedback cards there was no evidence to show that these had been analysed in a meaningful way and if any actions had been taken.

There was a range of information leaflets in the reception to inform people about the service and an up to date Statement of Purpose which informed people about what services and facilities were available at the

home.

We looked at the service's maintenance records. We found that maintenance for the service of the gas and electrical appliances, fire, hoist and slings, emergency lighting and legionella checks had been carried out and certificates were up to date and valid.