Trees Park (Kenyon) Limited

Kenyon Lodge

Inspection report

99 Manchester Road West
Little Hulton
Manchester
Greater Manchester
M38 9DX

Tel: 01617904448

Date of inspection visit:
22 August 2017
23 August 2017
20 September 2017

Date of publication:
30 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Kenyon Lodge is owned by Trees Park (Kenyon) Limited, trading as Abbey Healthcare. The service is registered with the Care Quality Commission to provide nursing and personal care for up to 60 people. The single room accommodation is arranged over two floors and has lift access. On-site car parking is available and the service is situated on a local bus route and is close to the motorway network. At the time of the inspection 23 people were living on the ground floor nursing unit and 20 people were living on the first floor residential unit.

We carried out an unannounced inspection of Kenyon Lodge on 22 and 23 August 2017. We then carried out a further day of inspection on 20 September 2017 to check on the progress the provider had made since the date of the first inspection, and to check on people's welfare. The inspection had been brought forward due to a significant number of safeguarding issues and concerns, including one serious incident. We are making further enquiries in relation to this incident.

When the home was inspected on 06 October 2015 the home was given an overall rating of inadequate and was placed into 'special measures' by CQC. The service was re-inspected on 25 May 2016 and again on 26 October 2016, where improvements were noted and the home was given an overall rating of requires improvement.

During this inspection, we found multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in regard to safe care and treatment, safeguarding, meeting nutrition and hydration needs, good governance, person-centred care and staffing requirements. We are currently considering our enforcement options in relation to these regulatory breaches.

At the time of the inspection, there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A manager had recently been appointed but had not yet commenced their application with CQC.

People and their relatives told us they did not always feel they were safe living at the home. Relatives told us they felt the home was short staffed and people's needs were not met in a timely way as a result of this. We received negative comments regarding the care provided. One relative told us [their relative] was unkempt and they didn't have confidence in the care because nurses were not always sure about the treatment [their relative] had received. One staff member told us they would not want their own relative in the home.

People were not safeguarded from abuse as staff were not recognising safeguarding incidents and referring them to the local authority. We found at the time of the inspection there was a high number of safeguarding incidents, currently being investigated. Of these, the majority had been raised by visiting health care professionals.

A number of the safeguarding concerns related to the management of pressure care and wounds. We found information regarding the management of pressure care was inconsistent and differing instructions relating to the frequency pressure relief should be provided. This had placed people at risk of their skin breaking down.

Medicines were not handled, stored or administered safely. Effective systems for the safe administration and storage of drink thickeners were not in place, which placed people at risk of harm. Although medicines had been audited regularly, audits had failed to identify the issues we found during the inspection regarding the unsafe management of medicines.

The building was being adequately maintained, which ensured the premises were safe. People were protected from the risk of infection, as the provider had ensured good infection control practices were in place. This had been verified by the local infection control team.

Staff including the cook and kitchen staff did not have access to information and guidance about people's nutrition and hydration needs. This placed people at risk of choking or aspiration. For people, who required their food and fluid intake to be monitored, record keeping was poor, and there were no system in place to check records had been completed, and act on any identified issues.

Staff were being recruited safely, and once in post had access to an induction programme. Staff had not consistently received sufficient training and supervision to ensure they had the skills required to support people effectively.

Care plans had not been reviewed regularly and updated to ensure they reflected people's current needs and preferences. Record keeping was poor. People did not consistently receive care that met their needs and preferences.

There was a complaints policy and procedure in place in addition to a complaints log and details of how to complain were posted around the building.

We identified significant shortfalls in the care provided to people at the home. This was linked to ineffective governance arrangements and leadership both by the provider, and through the management arrangements in place at the home. A monthly log of accidents/incidents was kept. However these had not been audited by the provider to identify any trends or patterns to prevent re-occurrence. The provider had failed to notify CQC of several notifiable events.

We shared our concerns with local commissioners, who have undertaken reviews of all people living in the home, and supported the provider in making immediate improvements to ensure people's safety. Following the inspection the provider submitted an action plan to CQC and commissioners identifying how they intended to address our concerns. The action plan is being updated and shared regularly.

The overall rating for this provider is 'Inadequate'. This means that the home has been placed into 'Special measures' by CQC.

The purpose of special measures is to:

•□Ensure that providers found to be providing inadequate care significantly improve;
•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made;

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

People were not safeguarded from abuse.

Individual risks to people who used the service were not always adequately assessed and acted upon.

Staff were not deployed in a way that ensured people received care that met their individual needs and preferences.

Medicines were not administered and stored safely.

Is the service effective?

Inadequate

The service was not effective.

Staff did not consistently receive training and supervision as required.

The service was unable to demonstrate how it was meeting the nutritional and hydration needs of people at high risk of malnutrition.

Advice provided by other professionals such as speech and language therapists was not followed.

The principles of the MCA 2005 were being followed to ensure that people who lacked the mental capacity to agree to their care were supported in their best interests.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

Some staff did not always interact with people who used the service in a manner that respected their dignity.

People were left in lounges with little engagement and staff oversight to maintain their safety.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care did not always meet people's needs and reflect their preferences.

Accurate records were not always maintained by staff with regards to people's care.

A complaints system was in place.

Is the service well-led?

Inadequate

The service was not well-led.

At the time of our inspection there was no registered manager at the home.

Systems for audit and quality assurance were not effective.

The provider had failed to notify CQC of serious incidents involving people who used the service in line with their statutory requirements.

Kenyon Lodge

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.

The inspection was unannounced. On 22 and 23 August 2017 the inspection team consisted of four adult social care inspectors from Care Quality Commission (CQC) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert was experienced in dementia, palliative care and older people in a residential, community and NHS setting. On 20 September 2017 the inspection team consisted of one adult social care inspector and one adult social care inspection manager.

The inspection had been brought forward due to a high number of safeguarding issues received within a short time frame. The provider had not notified CQC of these issues. These were shared with CQC by the local authority and clinical commissioning group (CCG).

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

During our inspection of Kenyon Lodge we spoke with five people who used the service, five visiting relatives, eight members of staff directly involved in providing care, including three nurses, four managers including the area operations director, the area support manager, the acting manager and the new manager.

We looked in detail at six care plans and associated documentation, supervision and training records, five staff records including recruitment and selection records, audits and quality assurance, a variety of policies of procedures, safety and maintenance certificates.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us.

We undertook 'pathway tracking' of care records, which involves cross referencing people's care records via the home's documentation. We observed care within the home throughout the day in the lounges and communal areas.

We observed the medicines round and the breakfast and lunchtime meal. We toured the premises and looked in various rooms. We also reviewed previous inspection reports and other information we held about the service.

Inadequate

Is the service safe?

Our findings

People we spoke with and their relatives did not feel they were always safe living at the home. One relative said, "The rooms are left unlocked and [my relative's] slippers have gone missing because of a couple of people being allowed to wander into other people's rooms." A second relative told us, "The bedroom doors are always left open and other residents wander into [my relative's] room. There's also been an issue for a while with the buzzer not working. [My relative] just tends to shout now."

This comprehensive inspection had been brought forward in response to CQC being made aware of a number of safeguarding alerts and concerns within the service. During the inspection we found the provider's safeguarding systems had been ineffective in ensuring people were protected from abuse. The majority of safeguarding referrals had been made by health professionals and had not been identified by the service's own staff. For example, concerns about the standard of wound care being provided had not being identified and referred by the provider's nursing staff, and instead had been picked up by external professionals.

The provider had a safeguarding and whistleblowing policy in place. Safeguarding training levels required further improvement with 62% of staff having received training. Staff responses on their understanding of safeguarding were mixed. One member of staff said, "I would report any concerns straight away. If I saw anybody with bruises which were not normal or people's personal care was being neglected could be abuse." A second staff member said, "There have been times things haven't been in place for this but since the new manager started she's upped the game on this. I would report any safeguarding issues but confidentiality about general stuff isn't great. It gets leaked out and discussed with others." A third said, "I've never been told about safeguarding, I've had no training at all on that."

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding.

We observed the use of drink thickeners, which are prescribed to people who may have swallowing difficulties, were not being administered effectively or stored securely. We saw thickeners unsecured on drinks trolleys next to the kitchen area of the nursing unit. We were told only one person on the unit was mobile. However this could present a greater risk for the person as they would be unable to distinguish the contents and whether they were safe for consumption.

On revisiting the home on the 20 September 2017, we found there were no effective systems in place for the management of thickeners and the provider had not followed National Patient Safety Alerts (NPSA) guidance regarding the storage of thickeners in care homes. Staff had no guidance on how to make the thickener to the correct consistency which placed people at risk of aspiration and staff did not treat thickeners as a prescribed medicine. The provider provided evidence following these findings that a system had been put in place.

We looked at how people were protected against the risk of choking and aspiration. We reviewed the care

plan of one person who had been referred to SALT due to being at risk of choking when eating and drinking. The SALT team had advised that this person was provided with a fork mashable diet to help them consume their food safely. We reviewed a sample of food records from August 2017 to establish if these recommendations were being consistently followed by staff. On seven occasions, we noted this person had been given foods not in line with their assessed needs for their dinner, which was not a fork mashable option as had been advised and could have place this person at risk.

These issues meant there had been a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment as people had not been protected from the risks of choking or aspiration.

We found medicines were not administered safely. We observed the morning medicines round on the nursing unit. The nurse potted nutritional supplements into a named pot and the care staff gave these to people. Whilst administering medicines the nurse was interrupted by a carer who requested the nurse apply a dressing to another person. The nurse locked the cabinet and went to complete this, but left the unidentified tablets from this person on top of the cabinet, which meant that anyone passing the trolley would have had access to them. The nurse told us that ideally she would not be distracted from the medication round.

We observed another medicines round administered by the senior carer who was wearing a red tabard indicating she was not to be disturbed. Whilst administering these medicines the senior carer left the medicines trolley in the corridor outside the dining room and this was left wide open with medication both inside and on top of the trolley which could be accessed by people passing by. The keys to the medicines room were also left on top of the trolley whilst the senior carer gave medicines to people out of sight of the medicines trolley. We prompted the staff member to shut the cabinet and keep it secure when they left it. Subsequently we observed they mainly complied with this but still did not always remember to shut the cabinet whilst administering medicines. The senior carer explained they felt it was safe because everyone was in the dining room and those who weren't were not mobile.

The application of prescribed creams was not being consistently recorded. For example, one person required double base cream to be applied by care staff. We looked at records for the period 23 July 2017 to 26 July 2017 and found these had not been completed on 12 occasions during the period which meant it could not be determined this cream had been applied as necessary. Another person had creams prescribed to maintain their skin integrity. Care staff applied people's creams and the nurse recorded this on the MAR. We asked the nurse where the carer's signed to indicate they had applied the cream. The nurse said that she believed there were charts for this but was no longer sure where they were.

We found information recorded about two people's medicines was unclear. For example, one person received a medicine for 'episodes of restlessness and agitation.' Possible side effects were listed and when to call the GP for advice. Their MAR sheet indicated this was needed four times a day, however the PRN protocol identified a maximum three doses in 24 hours, which was contradictory and could have resulted in the person not receiving treatment when required and experiencing unnecessary side effects.

Medication fridge temperature records were incomplete with significant gaps noted in August 2017. Certain medicines must be stored at lower temperatures in order to maintain their therapeutic value. Because records were incomplete we could not determine if medicines stored in the fridge had been adversely affected which could have effect the efficacy of people's treatment.

These issues meant there had been a breach of Regulation 12 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 in relation to safe care and treatment, as medicines were not being administered safely.

We asked people and staff if they felt there were enough staff on duty to safely provide care, one staff member said, "100% not enough staff, we are always really under pressure." A second told us, "There are not enough staff; there are five care assistants in today which is a big shock. Usually we have four and we struggle because the nurses don't always help out. There have been times in the past when only three care staff have been on and weren't replaced." A third staff member commented, "We haven't got time to sit and chat with the residents at all."

A relative commented, "They seem to be very understaffed at times, particularly on a Sunday. On Sunday and Tuesday, [my relative] was still in bed at 11am because she needs two carers to use the hoist." A person who used the service told us, "There's not enough staff really."

We found that when determining the level of staff required the provider took into account people's needs and their dependency level, using a formal dependency level tool. However, as care plans had not been reviewed regularly and contained contradictory information we were unable to assess whether this provided an accurate reflection of the level of needs people had.

We observed care throughout the days of inspection and found staff were rushed and were unable to spend any significant amount of time with people in the lounge areas throughout the day. This meant people were left unsupervised.

This was a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing.

Care files contained personal emergency evacuation plans (PEEPs), which provided guidance on the support people required to vacate the premises in an emergency. We saw these had been reviewed monthly and updated to reflect changes in a person's situation, for example one person was now not cared for in bed, and their PEEP had been updated to reflect this change and the different approach staff would need to take, to assist them to evacuate.

We looked at health and safety and building maintenance records to ensure the premises was safe. Up to date certificates and checks had been completed in respect of gas and electrical safety, fire safety, hot water temperatures and portable electrical appliances. Upper floor windows were compliant with safety regulations and suitable window restrictors were in place. However one window restrictor was missing from the upper floor dining room middle window; we spoke with the handyman who fixed it immediately. Equipment used for moving and handling people had been serviced and maintained appropriately.

We reviewed a sample of five staff personnel files, including recruitment records, which demonstrated that staff had been safely and effectively recruited. The files included written application forms, a written record of the job interview, proof of identity, proof of address and at least two references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. This showed us staff were recruited safely.

The home had an infection control policy and procedure in place. We observed that the service followed appropriate infection control and prevention practice, for example using personal protection equipment (PPE) when providing support to people and at meal times. A recent infection control audit had been carried

out by Salford City Council on 4 May 2017 and the service had achieved a high score of 95% percent.

Inadequate

Is the service effective?

Our findings

We asked people and their relatives if they felt the service effectively met their needs and we received negative comments from everyone. One person said "I wouldn't pay the night staff in washers; I'm trying to sort my own bed out now from how it's been left."

A relative told us, "I have no confidence in them at all; the care's not there. A second relative said, "The night staff don't like [my relative] and have 'sent her to Coventry'; they even put her buzzer out of reach. One of the night staff has left now who was bullying her during the night; her daughter has actually reported the home to the CQC."

A staff member told us, "I wouldn't put a family member in here because of the building and the environment. Things have got to get to a bad stage before they do anything about it."

We checked to see how the provider ensured that staff had the required knowledge and skills to undertake their roles. There was an induction programme in place for both care staff and nursing staff. Newly recruited staff followed a 12 week formal induction programme. They undertook a range of basic mandatory training; and were required to read certain policies as part of this process. An induction checklist booklet was completed for each new staff member and this was used until the staff member was deemed competent. One staff member said, "An induction was provided. It covered fire safety, manual handling, safeguarding and infection control. I would say it gave me a good overview, but thankfully I had worked in care previously." A second told us, "The second day of my induction was changed because my supervisor was needed on the upstairs floor; I feel I haven't learned what I should have."

We looked at staff training records, which included details of training previously undertaken and dates for when training was due for renewal. We saw the training that had been offered to staff was inconsistent. The overall percentage of 'all required' training courses completed, varied from individual to individual. Some staff who had recently joined the home still needed to complete a full range of training and this was identified on the training spread sheet as 'In completion period.' Other staff members had completed most of their mandatory training. Since the inspection the provider has been providing updates on training levels. On the last update overall training levels were 63% against a target of 100%.

We asked staff if they had received enough training to ensure they could effectively carry out their roles, one staff member said, "There has been plenty of training since I have been here. I have done dementia, infection control, and manual handling. I would say training is sufficient." A second told us, "I have done training through e-learning." However a third said, "I haven't had training on dementia, everything I know is through my university course or self-taught. I would also like information on brain injuries and issues like schizophrenia, all the things that we're dealing with and some training on calming techniques."

We found staff did not consistently receive regular supervision and an annual appraisal. We saw from supervision records for 2017 that no supervisions had been recorded for January; three were recorded in February; one in March and 15 in April 2017. One staff member said, "I have been here since December 2016

and have never had a supervision or told when my appraisal will be." The provider's supervision policy stated, 'Every employee should be invited to a supervision session with the manager or supervisor at least 6 times each year and more if performance issues are under discussion.'

We found the service had failed to ensure staff were suitably qualified, competent, skilled and experienced; and that staff received appropriate professional development and supervision.

This is a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to staffing.

People with specific nutritional requirements were not having their needs met effectively, as professional advice was not being followed. For example, we reviewed the nutritional care plan of one person, which stated they had a history of gout and that staff should avoid foods high in uric acid. This would include certain meats and more specifically pork. When we reviewed this person's food intake charts, these showed they had eaten foods such as a chicken and pork dinner and bacon on toast. This medical information had not been communicated to the cook who was unaware of this information when we spoke to them. The nurse on duty was also unable to give us an explanation of why these foods had been provided. There was also nothing documented in the care plan about which foods to avoid for staff to follow.

We found there to be a lack of evidence on food charts and other nutritional documentation to show that professional advice had been followed. We saw a speech and language therapist (SALT) had recommended one person was offered citrus yoghurts and cinnamon or other spice based snacks regularly to stimulate swallowing due to issues with them pooling food in their mouth. We found no evidence to support these were being offered as recommended. A dietician had advised that one person should be offered milky drinks and have their meals fortified. We noted the fortified section on this person's food charts had not been completed consistently, so were unable to evidence this had been done. We also saw over the last seven days, the person's food chart indicated they had only been offered a milkshake on two occasions. Another person had been placed on a weight loss programme, under the guidance of a dietician. It had been requested this person be weighed monthly, however they had no weight chart in their file. Their weight had not been consistently documented on their malnutrition universal scoring tool (MUST).

On 20 September we found several people had very low fluid levels recorded. Of nine people's fluid balance charts, the range of fluid recorded ranged from 480ml to 1250ml. One person had 750ml fluid recorded for 19 September 2017 and the previous day had 720ml fluid recorded. With the exception of one person receiving end of life care, we were not able to ascertain from the management team why people were receiving lower levels of fluid than what you would expect. The forms did not identify a target amount for each person based on their needs. The service explained there was a system in place for responding when people were not achieving the required fluids but this system was not being adhered to at the time of our inspection. The area director later said staff had told them they were giving more drinks than what was shown as they didn't always record them. We found the systems in place for recording and monitoring people's food and fluids were ineffective, and we were therefore unable to determine if they had received adequate and suitable nutrition and hydration.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to meeting nutritional and hydration needs.

On the first day of the inspection a SALT was visiting and discussing a recent referral for one person with the nurse. The SALT said they had received a referral for this person on 16 August 2017 from the nurse. SALT explained they triaged referrals on the telephone and saw urgent cases within two days of referral and non-

urgent within four weeks. SALT had asked whether this person had had a recent chest infection which would have resulted in the person's referral being triaged as urgent due to increased risk of aspiration. The person had had a chest infection but this was not detailed in their notes and had not been communicated to SALT. We saw antibiotics had previously been prescribed 09 to 16 July 2017 for a chest infection. This meant the person had been exposed to the risk of harm as medical information had not been communicated to support medical assessment in the required time frame.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment in relation to timely referral to healthcare professionals.

Prior to the inspection we received concerning information about the management of wounds and pressure sores. We used this information as part of our inspection planning and looked at a selection of care plans where concerns had been raised. We saw information in care plans was inconsistent. For example we found differing instructions relating to the frequency with which pressure relief should be provided, or care plans did not contain the most up to date information about pressure areas or other wounds. We noted staff did not consistently follow the advice or guidance listed on care plans and risk assessments, or that provided by professionals such as podiatry and tissue viability nurses (TVNs). For example one person's feet had been found resting against the foot of the bed on three occasions by a visiting professional, prior to the date of the inspection despite advice for this not to occur which placed the person at increased risk of skin breakdown and discomfort.

There was conflicting information which meant staff did not have sufficient guidance to provide effective care. For example; one person's skin care plan stated they needed to be re-positioned hourly on the first page of the plan, but two hourly on the second page. Another person's skin care plan stated hourly turns, however other documentation in their care file indicated two hourly which meant the person at risk of increased skin breakdown and discomfort.

We looked at three people's 'turn charts', which the home used to record when people had received pressure relief and supported to change position. We saw that over the course of the previous week, gaps of up to five hours between pressure relief care had been recorded, with the overall frequency of turns inconsistent and not as regular as stated in care plans. On top of each 'turn chart' had been recorded how frequent repositioning should be carried out, to act as a guide and prompt for staff. However we noted the information recorded was not reflective of the guidance within the care plans.

On 20 September, we saw an action plan was in place and processes and procedures were starting to be developed to address the concerns and improve the standard and consistency of pressure care. Our review of documentation showed some improvements over the previous week prior to the inspection, with care files starting to be reviewed and updated, wound care being prioritised and discussed at two daily flash meetings.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care.

When we returned to the home on 20 September 2017, we found the provider had made progress to address these concerns. All wounds had been reassessed and documentation reviewed and updated. Changes in practice were found to have occurred. For example, visiting podiatrists had previously raised concerns that one person did not have dressings on their feet and did not have appropriate pressure relieving equipment in use. We went into this person's bedroom and found the dressings had now been re-applied. The podiatry service had also advised that their foot should be well supported and protected in bed to aid the healing

process. This person had a special blue cushion to place under their foot and each time we went into this person's bedroom we saw the cushion was being used to protect their feet.

We asked people and their relatives what they thought about the food provided. One person said, "The food's good but my breakfast time used to be 8.30am and now it's 9.30am because there's no staff." A second person said, "The food's not bad but there's not enough. I would like bigger portions but to be fair I've only asked for second servings of porridge. They don't starve you but for me there's not enough, others are happy with it." A relative commented, "The food's okay, [my relative's] usually having breakfast when I arrive. When she's gone off her food, they give her supplements like complan." A second relative told us, "[My relative's] supposed to get softer food or food cut up so that she can manage. They don't look after her the same when I'm away and I've been told she seems to be losing weight. I usually give her lunch when I'm there."

People were eating breakfast when we arrived at the home. Breakfast was a choice of cereal, porridge, toast and preserves, pastry and fruit and there was also a cooked option available if requested. We saw snacks and drinks were offered throughout the day. There was a food hygiene policy and we saw that staff had completed training in food hygiene. The service had received a food hygiene rating score (FHRS) of three prior to the date of the inspection and the cook told us this was due to the need to replace windows and splash backs in the kitchen. There was a four week rolling menu which was placed on each table and people had a choice of at least two options at each meal. Allergen information was identified including the food name and its allergen content, such as soya. Each person had a 'meal chart' which identified their dietary requirements, including any dietary/fortified supplements, if gluten free, low fat or coeliac.

The cook had a good knowledge of people's individual food likes and dislikes and described how they did not use any frozen foods for main meals and how people could choose an alternative option to the menu if they preferred. For example one person had previously requested and been provided with tripe, which was not on the ordinary menu. The kitchen areas were clean and staff wore personal protective equipment (PPE) as required and used different coloured chopping boards and designated preparation areas for different food items. Food temperatures were checked before each serving and fridge/freezer temperatures were taken daily as necessary.

At the lunchtime meal there was a relaxed atmosphere and we saw that staff interacted with people in a respectful and dignified manner and encouraged people's engagement. Staff provided assistance to people who required it and spoke politely to people confirming with them what they wanted to eat and drink before serving it.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. The MCA/DoLS require providers to submit applications to a 'supervisory body' for authority to do so and we saw that the service had made the

appropriate applications as required. At the time of our inspection, there were a number of people living at the home who had a DoL authorisation in place and there had been one new application in 2017.

In one person's care file, we noted they had difficulty breathing whilst sleeping and had been provided with a machine to assist them with this. The person had been refusing to wear the machine and as a result the home had held a best interest meeting with the professionals involved in the person's care to discuss this. As the person understood the risks involved in not wearing the machine, and consistently refused to do so, it was agreed they had capacity to make their own decision in regards to this despite the risks posed to their health.

One staff member told us, "I have done MCA/DoLS training through e-learning. It relates to when people may have their liberties taken away and can't make their own decisions." A second said, "I know all about MCA/DoLS." A third told us, "I've done the e-learning on MCA and DoLS but there's no practical side." Anyone subject to a DoL was identified, and information included the person's name and date of birth, their GP details, if they had an advanced care plan or 'do not attempt resuscitation' plan in place, the status of the DoL application. At the last update from the provider, 70% of staff had received MCA training.

During the inspection we toured the premises and looked at communal areas and bedrooms. Bedrooms were personalised with items such as photographs and pictures, although some were decorated plainly and lacked an element of personalisation. A programme of redecoration was underway which we observed included wallpapering in one communal area and painting in the corridors, which contributed to a more 'homely' feel. We noted the rubber flooring in the lift was 'bubbled' which may present a trip hazard. We spoke with the handyman who told us quotes had already been obtained for the replacement of this floor. A staff member said, "The environment is scruffy and tired. The carpets are very old but they have started decorating; there were no discussions with staff but it's starting to look better. Another told us, "I would have preferred the refurbishment programme to start with individuals' rooms."

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives if staff treated them with kindness. One relative said, "I can't fault it for [my relative] there's been a few niggles now and again but they've always been sorted." A second relative told us, "[My relative] had a bad fall at Christmas whilst she was out with us and the carers were great and always there for her." A third said, "The carers look after the residents the best they can and most of them are very friendly and welcoming." A person who used the service said, "I wouldn't have been looked after better if I was private." A second told us "The staff are good; they try to help without being too interfering."

We saw people chatting to staff and enjoying each other's company. We saw instances where staff took the time to speak to people and enquire about their welfare or inform them of what was going on. Despite this, we observed people were left alone in the communal lounges with little engagement and oversight to maintain their safety or respond to their needs as staff were engaged in other duties.

We observed staff were not always discrete when supporting people with personal care. For example; one staff member was assisting a person who used a wheelchair towards the toilet on the upper floor of the building. As they approached the toilet door we heard them say in a loud voice to another staff member who was situated further down the corridor, "Does he stand up when he's having a wee." This could have been heard by anyone in the area and most importantly, by the person them self and showed a lack of understanding regarding maintaining the dignity of this person.

We asked staff how they ensured people were treated with dignity and respect and promoted people's independence. One staff member said, "I always close the doors during personal care and make sure I explain the care I am going to provide. I will ask people what they want instead of just assuming everything which shows respect." A second said, "I will allow people to eat themselves or pass them a flannel during personal care so that they can do a bit for themselves." However a third told us, "We try to do our best but there's just not enough time." A person who used the service said, "There's quite a few good staff here. (Staff name) is really good but one of the kitchen staff's attitude is appalling. There's quite a lot of issues here really."

On one occasion a staff member had written 1 / 2 hourly on the top of the turn chart, which some had interpreted to mean one to two hourly, however a member of the night staff had read as half hourly and provided half hourly pressure relief throughout the night, which would have been very disruptive and upsetting for the person, who would have had little sleep.

During our inspection we looked to see how the provider promoted equality, recognised diversity, and protected people's human rights. We found the provider had policies and procedures covering personalised care, treatment and support; autonomy and choice; service users contract; dignity and privacy; independence and fulfilment, person-centred care planning and equal opportunities. These policies gave guidance to staff on how to ensure that people lived in an environment where their diversity was celebrated and respected and where they could live free from discrimination and prejudice.

We observed during the inspection that although people's bedroom doors were usually left open, which was their choice, staff used the inner en-suite bathroom door as a screen if they were supporting people in their own rooms. On several occasions when staff were passing by people's rooms we saw they enquired how the person was, comments included, "Morning [person name] what time did you get up – are you comfortable," "Come on [person name] let's find a comfy chair for you."

We saw at breakfast, staff were observant and attentive to people's needs. For example; one person had finished their porridge and was immediately offered a second serving which they accepted. This person had sight impairment and was gently and discretely informed where their dish was and the staff member clinked the spoon on the dish to aid them to find it.

We observed another person going on an outing with their family member and we overheard the staff member asking, "Any preference what you want to wear today." These observations demonstrated staff involved people in decisions about their life and explored opportunities to promote people's independence.

We looked at how end of life care (EoL) was delivered. The service followed the six steps end of life care programme which is intended to enable people to have a comfortable, dignified and pain free death. The provider had an end of life care register in place, which listed each person within the home who was currently on one of the six 'steps' pathway and nursing staff completed a monthly review to decide whether the current stage was still appropriate to reflect their situation.

One person whose care we tracked, had been added to the register in March 2015 and placed on stage one, which indicates they had an advancing disease. This person had remained at stage one since that time, due to remaining stable and the staff managing their condition.

We saw where people had been willing to discuss end of life wishes, advanced care plans were in place which clearly documented the person's wishes at this stage of their life, including where they wished to receive treatment and where they chose to die. Care files documented whether a person had a DNACPR in place, with a copy of the form located at the front of their file.

Requires Improvement

Is the service responsive?

Our findings

We asked people and their relatives if the service was responsive to their needs. One person told us, "Sometimes when people want to go to the toilet they wait too long but that's down to staffing numbers." A second said, "I can't go outside unless I'm taken and some people don't go out at all. I would like a bit more to do with exercise and physiotherapy."

During our inspection we case-tracked six people and reviewed their care plans. We saw some evidence of people's preferences being collated within the care files. Each person's care plan contained a care plan involvement form, which was used to evidence the input of the person themselves or their family in care planning and assessments. However we saw that whilst involvement had been captured at the time the plans were initially set up, on-going involvement had not been documented.

Each file contained a 'This is my life history' section which contained personalised information about their childhood, adolescence, adulthood and later years. Each person also had a social assessment in place on which they had indicated who in their life was most important to them.

We saw some good examples of specific care planning when assessments had identified an issue, for example that one person had arthritis for which an individual care plan had been drawn up to manage this. However despite some evidence of person centred planning, we noted care files contained a large amount of standardised documentation with limited personalised information recorded. For example each person's needs assessment involved selecting either a, b or c to reflect their needs, which then indicated which pre-written management plan was relevant.

Care plans were not being updated consistently to reflect changes to people's needs or circumstances, with any new information being recorded on the care plan review sheet. This meant that guidance on the actual care plan was incorrect and staff would have to read the care plan and all the review information to ensure they knew how to care for the person.

Information within care plans was found to be contradictory. For example, one person's mini mental state assessment indicated they had capacity to make decisions and communicate. This was contradictory to the mental well-being care plan however, which stated they did not have capacity to make their own decisions. Their nutritional assessment was also contradictory to their social assessment. Their nutritional assessment stated they like all foods and did not dislike anything. However their social assessment said they disliked spaghetti bolognese and pasta. Their skin care also stated they required re-positioning every two hours by staff to protect their skin, whilst the monthly reviews stated this should be done every hour. We asked a member of staff about this and they said it was done every hour; however records indicated it to be a combination of both. This presented the risk of staff not having access to up to date information about people's care needs.

We found the quality and standard of care files varied greatly in regards to detail and overall makeup of the file. One file we looked at was very untidy, the metal rings were broken, which caused paper to fall out, the

file contained no index and a number of dividers were missing, which made it difficult to navigate.

This meant there had been a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, accurate records were not being maintained for each person using the service.

We checked to see if people living at the home received care that was responsive to their needs and in line with their preferences and choices. We reviewed one person's communication care plan, which stated they had poor eyesight and needed to wear glasses all the time. We went into this person's bedroom and saw their glasses were on the bed side cabinet out of reach. We raised this with a member of staff who said they did usually wear them, but must have been taken off during personal care.

In another person's care plan, their Waterlow risk assessment said they were at very high risk of skin break down and were required to be sat on a pressure relieving cushion when seated. We observed this person sitting in the lounge during the afternoon of the inspection. However, they weren't sat on a pressure relieving cushion. We raised this with the nurse who was unsure if the chairs themselves provided pressure relief and then told a member of staff a cushion needed to be provided.
This person's personal hygiene care plan also stated they liked to wear an apron at meal times to protect their clothes; however they weren't wearing one when observed eating their lunch during the inspection. They also required a hearing aid, however weren't wearing one during the inspection. There was a note in the professionals log from audiology stating the right moulds were loose and new impressions were being taken. We raised this with the nurse in charge who said it was their first day back in work for several weeks and would follow this up.

This meant there had been a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care, as care and treatment did not always meet people's needs and reflect their preferences.

During our inspection, we checked to see how people were supported with interests and social activities. There was a hairdressing salon in place and we saw three people accessing this facility on the first day of the inspection. Pictures of activities previously undertaken were posted on a notice board in the entrance area. The home employed two part-time activities co-ordinators, one of whom was not in work during the inspection.

The activities co-ordinator told us that a list of on-going activities was usually displayed around the home but they had not had time to do it. We saw activities previously undertaken included one-to-one support, DVD's, newspapers, lunches out, reminiscence, mobile library, gardening, special celebration days, raffles, visiting entertainers, art and crafts.

Each person had an activities care plan and a care pathway to support activity needs. These identified information about each person and their likes and dislikes regarding activities. When people had undertaken an activity these were recorded in their individual activity record. For example within one week one person had undertaken: a pampering session; chair based exercises; bingo; quiz; had lunch out; a coffee morning at another location; received holy communion; sing-along with instruments.

On the second day of the inspection there was a Hawaiian themed day with a visiting entertainer. People wore Hawaiian style clothing and sang along to a variety of music, and enjoyed this activity. The activities coordinator had a good understanding of each individual and their changing needs. They said, "People's needs are changing and we need take think about taking a different approach and doing more one-to-one

work with people who don't like group activities. I now have another member of staff employed to do activities with me."

We asked people and their relatives about their views of activities, one person said, "I like my own company and the TV. I like to watch (TV programme), it keeps my mind active and I'm having my haircut today. The vicar comes in once a month but I don't believe in all that." A relative told us, "[My relative] likes her own company, watching TV and reading the newspaper. She occasionally joins in with the craft centre and has tea with the vicar once a month. She's also been out with (staff name) a couple of times on the bus and she enjoyed the trip to the farm."

We looked at how complaints were handled. There was a complaints policy and procedure in place in addition to a complaints log and details of how to complain were posted around the building. Where people were unhappy about any local investigations they could contact the provider's quality and compliance director. The complaints procedure identified details for the Local Government Ombudsman (LGO) the local authority or CQC. Complaints records we saw identified the provider had responded in accordance with their procedure. However, we saw one record for January 2017 where an initial response to the complainant had been provided but there was no information regarding any subsequent action taken. The majority of the people we spoke with didn't know about the complaints procedure. However, they stated that they would not hesitate to bring any concerns to management.

We looked at compliments previously received by the service and comments included: 'Thank you so much for taking care of my mum, I know you have all done your best for her;' 'Thanks you for looking after my mum for the last eight years, I don't know what I would have done without you;' 'To everyone who looked after my mum just to say a huge thank you, she loved you all.'

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. On the third day of the inspection we found a person had commenced in the role of manager but had not yet started the process of registering with the Commission. We spoke with the area operations director about this who told us they were aware of the need to submit an application.

The home was rated as requires improvement at our two previous inspections and was inadequate prior to this. This meant the provider had failed to improve the overall rating of the home from 'requires improvement'. The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'Good' or 'Outstanding' at this inspection. This had not been the case as we found the quality of care received had deteriorated, which meant the quality of service provided to people living at the home was not continuously improving over time.

We asked staff about their views of management. One staff member told us, "We never see the manager and she is never on the floor; always in the office like she is today." A second said, "There's no support from management and nothing is confidential with them. I reported a staff member and I would always report things even though they don't always do anything about it and it gets out to others." A third commented, "Management don't listen to you and the nurses are the same, they think we're just carers; it's going back downhill; nobody checks anything here and they should do."

We asked people and their relatives if they knew who the manager was and what their opinions were of them. One relative said, "The manager does try to rectify things and things have improved slightly but it depends which staff are on. However, I've rang at night to ask about [my relative] and they gave me an update that wasn't even about [my relative]; it's just parrot-fashion speech." A second relative told us, "I have the manager's mobile number but when I ring her number it just gets cut off and no-one ever returns my messages. I'm actually away at the moment and my friends have updated me on [my relative] but I've heard nothing from the home."

During our inspection we found a lack of co-ordinated leadership, which was impacting on the quality of care provided. This lack of management oversight had further deteriorated since the last registered manager left the service in February 2017. When we returned on the third day of our inspection we found although records relating to the management of wound care had improved other issues we identified during the first two days of the inspection had not been rectified, which gave concerns regarding the quality of management oversight. Day-to-day clinical and operational leadership of staff was inadequate and the provider, Abbey Healthcare, had failed to provide sufficient oversight to recognise and respond to emerging issues identified at the inspection.

Despite the audits and quality management systems in place, we noted gaps within records such as weight monitoring not completed consistently and care plans had not been updated to reflect actual changes to practice or the person's need; these had instead been added to the review section, which if not read when updated would result in incorrect care being provided.

We looked at how accidents and incidents were audited and found that although these were being logged the provider did not have effective systems in place to identify any patterns and trends with each person concerned. When we returned on the third day of the inspection the provider showed us an updated accident/incident analysis which had been introduced after the first day of the inspection. This analysis, written by the provider, stated there had been poor record keeping regarding these incidents and there were trends that had not been previously identified. We also found ineffective systems for audit and quality assurance of care plans, as the provider had failed to identify errors and omissions in recording.

Although medicines were audited regularly using a document titled 'weekly sample audit tool – medication administration' and a document called 'staff competency assessment – medication administration' these interventions had failed to identify the issues we found during the inspection regarding the safe management of medicines.

We looked at how accidents and incidents were managed. A monthly log of incidents was kept. The log included an injury code, details of the incident, date and time, body map and details of the actions taken to mitigate the potential risk for re-occurrence. However these had not been audited by the provider to identify any trends or patterns.

We asked about formal satisfaction surveys for people who used the service and their relatives. We were told no surveys had been undertaken for 2017. People were able to provide feedback to the service by using a suggestion box and review cards located in the reception area. However, we found that involvement of people who used the service and/or their representatives through the use of residents or relatives' meetings was not consistent. The last meeting with residents and their family members had taken place in May 2017 and no other records were made available to us on the day of the inspection. Discussions at this meeting had included poor communication from staff, missing items of clothing, residents being left in bed, staff not present in lounges, lack of activities, and environmental issues.

These issues meant there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance.

We looked at the most recent staff satisfaction survey undertaken and were provided with thirteen responses which represented less than 50% of the overall staff group. We saw responses were mixed with four responses indicating dissatisfaction with training, information and feedback supplied to them by their line manager, the frequency of supervisions, overall job satisfaction and if they felt the provider cared for them.

We asked staff if they held regular meetings. One staff member said, "We do have but I feel it's more a case of being spoken at rather than staff being able to voice their opinion." A second told us, "We don't have staff meetings on a regular basis. I've never had an appraisal, no supervisions, no reviews, to be honest I don't even know I've got the job!. Morale is dead low at the moment; we just think nothing is right." However a second staff member said, "I don't have any problems with management and do feel supported by the new manager. (Staff Name) is a character and can be a bit too harsh, abrupt and rude but he does get things done.
Following the inspection the service submitted an action plan to CQC identifying how they intended to

address our concerns. This will be looked at during our next inspection of the home.

Providers are required by law to notify CQC of certain events which occur in the service. Records indicated that the provider had failed to notify CQC of several notifiable events. We looked at the statutory notifications file and saw that recent safeguarding incidents had not been recorded and there were no records relating to a high number of recent safeguarding issues we had been made aware of. We asked the acting manager about this on the first day of the inspection who explained they did not know they had to send a statutory notification to CQC if the safeguarding had been raised by another organisation. We asked the provider to submit all outstanding notifications to CQC on the day of the inspection. We are currently considering our options in relation to this issue.

We saw the ratings from the last inspection were displayed in the home.