Mr David Hetherington Messenger

# Carson House Care Centre

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

This inspection took place on 28, 29 and 31 August 2018 and the first day was unannounced.

Carson House Care Centre is a 'care home' situated in Stalybridge in Tameside, Greater Manchester. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Carson House accommodates up to 45 people. The home is divided into four units. Each unit consisted of a lounge, dining area and small kitchen facilities. One unit provides general nursing care, one unit provides mental health nursing for men who have behaviours that challenge and the other two units provide mental health nursing for men and women in separate units. There are two enclosed patio areas at the rear of the building which were used as smoking areas and were accessible to people who use the service.

During our inspection some people moved to other services and others were being offered alternative homes to move into. At the end of our inspection there were 25 people living in the home.

At our last inspection in December 2017 and January 2018 we rated the home inadequate overall and identified multiple breaches of the regulations. At this inspection we found limited evidence of improvements. We found improvements had been made in relation to training and supervision and the provider was meeting the requirements of this regulation. There remained ongoing breaches of regulations relating to the provision of safe care and treatment in particular; health and safety and medication, safe recruitment practices, person centred care and governance. We also found continued breaches of the Care Quality Commission (Registration) Regulations. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to the back section of reports after any representations and appeals have been concluded.

There was no registered manager in post. The service had a manager who had been in post since September 2017 and at the time of our inspection was in the process of applying to become the registered manager of the service. However following our inspection, we were informed that the manager had withdrawn their application. 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.

Following our last inspection, the registered provider had informed CQC that they were actively involved in the day to day running of the home and attended the home on a monthly basis to engage with residents and staff. We found no evidence to support this during our inspection.

We found there was little evidence that the issues relating to the maintenance and upkeep of the building identified at our previous inspection had been rectified. We continued to find defective lighting, a lack of fire

signage and hot water that posed a scalding risk.

People did not always receive their medicines safely. Stocks of some creams indicated they had not been used as often as prescribed and some checks on people's blood sugar levels had not been carried out as required.

Appropriate checks were not always completed on staff before they started working at the home. Full employment histories were not recorded and gaps in people's employment were not explored.

The home was generally in a poor state of repair and although a few rooms had been recently re-decorated the remaining rooms were in need of decoration. The smoking areas were untidy with cigarette ends and other litter.

People living in the home and their relatives spoke highly of the care staff. Throughout our inspection we observed caring and respectful interactions between staff and people living in the home.

Relatives gave us examples of how the rapport staff had built with people enabled staff to encourage people to be more receptive to being supported. People told us the staff knew them well and understood their needs.

People told us they felt safe in the home and relatives told us they felt their relatives were safe. Staff were aware of how to identify and report concerns and where concerns had been raised by staff they had been investigated appropriately.

Staffing levels were adequate in the home and people received support in an unhurried way. A number of staffing agencies had stopped supplying staff to the service because of unpaid bills and there was concern about how the home would be staffed if care workers left.

During our inspection staff were extremely unhappy that they had not been paid fully on time but did not let this affect the level of care and support they provided to people living in the home.

Efforts had been made to record the types of activities people wanted to do and took part in but the activities available on a day to day basis were ad-hoc and did not reflect people's preferred activities.

Staff told us the manager had made a positive difference to the home since they had started and gave us examples of improvements they had made.

We found systems in place to monitor the safety and quality of the service were ineffective.

The overall rating for this service is 'Inadequate' and the service remains 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.

Health and safety risks identified at our last inspection had not been addressed.

People did not always receive their medicines as prescribed.

Appropriate checks were not always carried out on staff before they started work at the home.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Some training and supervision records were out of date, however staff told us they felt supported and we observed good practice from care staff.

People's needs and choices were recorded and kept under regular review.

People told us they enjoyed the food in the home.

### Is the service caring?

**Good**

The service was caring.

People living in the home told us they felt the staff were kind and respectful. We observed good interactions between staff and people in the home.

People were encouraged to be as independent as possible.

Staff had not been paid fully on time for the last 3 months but this did not affect the level of care they provided to people.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Daily activities provided to people were limited and did not

always reflect their interests.

Complaints were investigated and lessons learned from them. People told us they felt able to raise issues.

Processes and procedures were in place if people needed care as they approached the end of their lives.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was little evidence that attempts had been made to rectify the shortcomings identified in previous inspections.

Some quality systems had been put in place however they had failed to identify and rectify the health and safety issues that had continued to be present.

There continue to be concerns about the financial sustainability of the service.

# Carson House Care Centre

**Detailed findings**

## Background to this inspection

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

This inspection took place on 28, 29 and 31 August 2018. The first day of the inspection was carried out by one adult social care inspector and a pharmacist specialist, the second day by one adult social care inspector and a health and safety specialist, the third day by one adult social care inspector.

Before the inspection we reviewed information that we held about the service and the service provider. This included notifications which the provider had told us about, information from other agencies such as the local authority and clinical commissioning group and information from whistle-blowers and the general public. Prior to our inspection we had received information raising concerns about the payment of staff and staffing agencies.

During the inspection we spoke with the manager of the service, the activities coordinator, seven people living in the service, four relatives of people and eleven members of staff, including nursing staff, care staff, domestic and kitchen staff.

We looked at the recruitment records of three staff, the care records of three people, supervision and training records, staff rotas and other records relating to quality and audit checks done by the home along with maintenance and servicing records. We performed checks on the temperatures of hot water.

During our inspection we used a method called Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We walked around the home and looked in communal areas, bathrooms, the kitchen, store rooms, medication rooms and the sluice. We also looked in a sample of bedrooms and the garden areas.

We also checked that the previous Care Quality Commission rating for the service was prominently displayed for people to see. The last inspection report and rating was displayed in the reception area. The service had a website which was under construction and the last inspection report and its rating were displayed.

Inadequate

# Is the service safe?

## Our findings

At our last inspection we found there was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 Safe care and treatment. A continuing breach is where the breach had been identified in the preceding inspection and had not been rectified. We identified concerns relating to the management of fire safety, maintenance checks being out of date and hot water outlets being hotter than the recommended temperatures for care homes. At this inspection we found no evidence that satisfactory remedial work had taken place and these issues were still present.

During our inspection we found that the testing documentation for fire safety was not detailed and did not explain what was being tested. We found that there was no evidence of actions taken following fire risk assessments. Following the last inspection, the provider informed us that fire zone maps had been put in place at the fire alarm panels however they were not in place during our inspection.

We saw no evidence the passenger lift had been serviced recently and there was no evidence the remedial work recommended at the last service in December 2017 had been completed. At our last inspection we found the passenger lift shaft lighting was not working and this continued to not be working at this inspection. We also found there was no evidence remedial works to the emergency lighting system had been carried out.

Portable Appliance Testing (PAT) should have been renewed in July 2018 and we found the record keeping about which appliances had been tested was poor. An engineer attended the home on the last day of our inspection to complete the PAT testing. During our last inspection we identified that the electrical test certificate issued in April 2014 was classified as unsatisfactory and a number of remedial works had been identified. We found there were no minor works certificates and there was insufficient evidence to support that all the remedial work recommended in 2014 had been completed. This continued to be the case during this inspection.

At our last inspection we found there was no evidence to confirm the hot water temperatures in the home were checked to ensure they were within the range recommended for care homes. At this inspection we saw records indicating checks were taking place however there were significant discrepancies between the temperatures recorded during the maintenance checks completed by the home and the temperatures we recorded during our inspection. The checks completed by the home identified a small number of slightly excessive temperatures however we found several temperatures significantly in excess of the recommended range.

We raised the risk of scalding to people with the manager during our inspection and they put in place risk assessments and control measures until the temperatures could be made safe. We also identified one window where the window restrictors could be over-ridden and were therefore not compliant for use in care homes. The manager immediately fitted an alternative restrictor.

The above examples demonstrate a continued breach of Regulation 12(1) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The service did not always manage and support people with their medicines safely. Medicines were stored safely and securely and access was restricted to authorised staff. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff carried out regular balance checks of controlled drugs.

Some people were prescribed medicines to be taken as and when required (known as PRN). We found most people had protocols in place to guide care staff how and when to administer these medicines. However, records did not always reflect the treatment people had received; when a variable dose was prescribed, staff did not always record the amount they had given on the MAR. A pain scoring tool was in place for people prescribed when required pain relief. However, this was only completed when pain medicines were administered rather than in accordance with PRN protocols to regularly assess pain.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. Body maps were in place to guide staff how and where to apply these treatments. We checked care records and found care staff did not always apply topical treatments as prescribed. For example, one person was prescribed a cream which should have been applied four to five times each day. The Topical MAR had only been signed on three days in August 2018 to indicate the cream had been applied. In addition, we found the cream in the person's room had been supplied in April 2018 and was still over half full. This suggested it had not been applied as often as prescribed.

Two people were prescribed a fluid thickener to be added to their drinks to reduce the risk of choking. We found information in care plans about how to thicken fluids to the correct consistency was not always up to date. We could not be sure care staff used the right amount of thickener because they did not record when they had added it to people's drinks. In addition, the staff member we spoke with could not tell us the correct amount of thickener to add to achieve the correct consistency. Not using thickener in the right way increases the risk of choking.

Three people were being given their medicines covertly (disguised in food or drink). For one person, we found appropriate capacity assessments and best interest decisions had not been recorded in accordance with the Mental Capacity Act. We also found written guidance was not available for two people about how to safely crush and administer these medicines to ensure this practice was safe.

One person was prescribed insulin to treat diabetes. There was a detailed care plan in place which set out the dosing instructions and the action staff should take if the person's blood sugar was outside the safe range. The home had received a letter from the diabetes nurse specialist requesting that the person's blood sugars were checked before every meal and at bedtime. We checked the person's blood sugar monitoring chart and found it had not been completed on 10 occasions in August 2018. This meant the person was at increased risk of harm from poor monitoring of their diabetes.

These concerns in relation to the safe management of medicines were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe care and treatment.

People using the service and their relatives told us they felt safe. One relative we spoke with told us; "If we ask them anything they will tell us and I can go home and relax knowing they are safe." We saw records showing staff had undergone training in safeguarding adults and staff we spoke with demonstrated they knew the signs that may indicate someone was at risk of abuse and knew what to do if they were concerned.

One staff member told us; "We know what to do if we're concerned. I've raised issues in the past and they have been dealt with."

Risks to people were assessed and where risks were identified additional assessments were completed to mitigate the risk to the person and allow them to be supported in the way they chose in as safe a way as possible. We saw these assessments were reviewed monthly and people's care plans were updated if the person's needs changed.

At our last inspection, we identified a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Fit and proper person employed. During this inspection we found the service was still not meeting this requirement.

We reviewed three recruitment files for people who had started work with the service since our last inspection. Two of the files contained no full employment history for staff and the remaining file contained missing dates in the person's employment history. One of the files related to a person previously employed by an agency. The service had relied on agency having done appropriate employment checks on the person and there was no evidence that the service's own checks had been carried out. Where people had previously worked in health or social care or worked with children or vulnerable adults, checks had not always been made about the person's conduct or their reason for leaving those roles.

This was a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Fit and proper person employed.

We reviewed staffing levels in the home during our inspection. We were told that staffing levels had been reduced as a number of people had moved or were moving out of the home. Staff working in the home told us they felt there were enough people on duty to support people safely. During our inspection we observed staff supporting people in an unhurried way and when call bells were pressed these were responded to in a timely manner demonstrating that there were enough staff on duty.

The service did sometimes rely on agencies to supply staff to work in the home. Prior to the inspection we received information indicating that three staffing agencies had stopped supplying staff as invoices for staff they had sent previously had not been paid and they had not been able to contact the provider. During our inspection we were told that an agency was continuing to supply staff to the home and as the numbers of people living in the home reduced the need for agency staff would also reduce. This is discussed in more detail in the 'well led' section of this report.

People were protected from the risk of infection. We observed staff using personal protective equipment (PPE) like disposable gloves and aprons when supporting people to try to reduce the risk of infection. Staff had undergone training in infection control practice during their induction although we noted some staff were overdue with their refresher training. The kitchen in the home had been inspected by the local authority and had been awarded a five star rating which is the highest rating meaning the cleanliness and management of the kitchen was good. The home was kept clean and we noted no malodour during our inspection.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection we found a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 Staffing.

Some training and supervision records were overdue at the time of our inspection however care workers we spoke with told us they felt supported by the manager and other team members. One care worker we spoke with told us; "We get the supervisions that we need. If we need to talk about something before a supervision we can go to people." Another care worker told us; "We do look after each other but we can go and speak to someone in the office if the manager isn't there."

We looked at records of supervisions and saw staff had been reminded about doing their online training to ensure they were up to date. Supervision records showed a regular issue raised by staff was the repeated failure of the provider to pay them their full wages on time. This is addressed in more detail in the 'well led' section of this report.

Staff told us they received a mixture of online training and face to face training and said they felt they had the skills needed to support the people living in the home safely. There was an area in the basement of the building which was used as a training area for practical sessions such as moving and handling. We saw records showing staff had undertaken refresher training to keep their skills and practice up to date.

The above demonstrated the service was now meeting the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 Staffing

People's needs were assessed and were reviewed monthly to ensure they continued to reflect the person's needs and choices. Care records we looked at contained information about people's choices and preferences in how they wanted to be supported, for example how the liked to dress or what toiletries they preferred.

People were supported to access other healthcare services. Where assessments and reviews identified people needed support from specialist services such as their GP, podiatrists or speech and language therapists (SALTs) we saw that referrals had been made and the advice from the specialists had been incorporated into the person's support plan.

People living in the home were registered with one of two local GP practices and GPs visited the home regularly. The home was also visited by an optician so people could have eye tests. People's care records we looked at contained up to date optical prescriptions.

Records were also maintained of visits made by other healthcare professionals such as GPs, podiatrists,

People we spoke with told us they enjoyed the food in the home. Meals were prepared freshly on the day and served on trolleys to keep them warm. There were dining areas in each of the units in the home and

most people chose to sit and eat at the tables but some people chose to sit in the lounge area.

At the time of our inspection two people were on pureed diets to minimise the risk of them choking. We saw the meals prepared for these people had been pureed and arranged attractively to look as much as possible like an un-pureed meal. People who needed support to eat were supported patiently and allowed to eat at their own pace.

We spoke to the staff working in the kitchen who told us they prepared meals according to the preferences of the people living in the home and prepared the meals on a daily basis. If people didn't like what was on the menu then an alternative would be provided.

A quality monitoring report completed by the service in February 2018 identified that the home should develop picture menus as soon as possible however this had not been actioned by the time of our inspection.

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.

We saw that the service had assessed people's capacity to make decisions, what support they needed to make decisions, and if the person's capacity was assessed to be impaired whether the impairment was felt to be temporary or permanent.

We saw evidence showing that where decisions had been made on a person's behalf, best interests meeting had been held with healthcare professions and relatives of the person and the decisions made during the meeting had been documented and incorporated into the person's care plan. One person's records showed an appointee had been appointed for them to help manage their affairs.

Some DoLS have conditions attached which detail steps the service must take to comply with the DoLS. A relative of someone living in the home explained the steps the manager had taken to ensure they complied with the conditions on their relative's DoLS.

People's rooms were personalised with pictures and personal items. The manager told us some people's rooms had been redecorated recently. The remaining rooms and communal areas, although clean, looked in a poor state of repair and in need of decoration. Some had chairs with very worn and damaged covers and radiator guards that were either warped or damaged.

Good

# Is the service caring?

## Our findings

People we spoke with told us they felt well cared for and that staff supported them well. One person we spoke with told us; "The staff are excellent. It's a community here." Another person added; "We're very happy, [staff member] looks after us." Relatives of people living in the home told us they felt welcome when they visited and also felt their relatives were well cared for. One person told us; "I'm very happy with the service, the carers are great. They look after [my relative]. Another person said; "They all do so much." Staff members we spoke with told us; "These people are like my grandparents, they're like family."

During the inspection we observed staff treating people with respect and compassion with an understanding of each person's preferences. We saw when a person complained of being in pain, the nurse immediately went to get the person's pain relief medication and a care worker tried to distract the person from their pain by singing with them. The care worker later told us; "We know [the person] likes to sing. They have a radio in their room and we always sing when we go in there."

People using the service told us they knew the staff well and felt the staff knew them well. We saw when staff started their shifts they would greet people cheerfully and people using the service responded knowing the member of staff's name. Relatives of people using the service also felt there was a good rapport between staff and people living in the home. One person told us; "[My relative] is hard to handle but they have taken a shine to [staff member]. [Staff member] is brilliant with them and can get them to do anything. Another relative told us; "Staff know [my relative] well and are very quick to pick up on things when they aren't well."

Throughout the inspection we saw people being offered choice and being allowed to make decisions about their care. We saw one person who was on a restricted amount of fluids because of their health asking for a drink. The care worker explained to the person they wouldn't be able to have a drink with their meal if they had a drink before and offered alternative solutions to the person. The person chose to have a drink and their choice was respected. We saw another person sat at a table and staff suggested they may be more comfortable sitting on the sofa. The person declined and staff respected their decision.

People were encouraged to remain as independent as possible. The young person's mental health unit had a washing up rota where people took turns to clear the kitchen area after meals. Where people were able to, they were also encouraged to take their own laundry to the machines. A relative of a person living in the home told us; "They get them to take their baskets to the laundry and they sort their own washing out." The female mental health unit had a separate laundry area with two washing machines however both machines were broken. One had a sign dated 5 December 2017 indicating the machine had broken down. A member of staff told us; "The washing machines don't work. It used to be nice as people could just pop their own things into the machines. Now we have to take them downstairs to use the machines there."

People's communication needs were identified and recorded in their care files so it could be shared with other care providers as required. We saw one person's care files indicating a person had hearing aids but chose not to wear them. We observed staff crouching to the person's height and speaking to them clearly and slowly as suggested in their plan to ensure they could communicate effectively.

As mentioned in the Effective and Well Led sections of this report, during recent months the staff had experienced delays in receiving their full pay and were again not paid fully on their pay day during our inspection. Despite this they did not let their frustrations affect the level of care they gave to people living in the home. A care worker we spoke with about this told us; "These people come first, we can't panic in front of them, we do all our flapping at home." The continued commitment to people living in the home was a credit to the care staff.

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection we found the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care as there was a lack of meaningful activities provided to support people's mental wellbeing, promote independence and prevent isolation.

During this inspection we were told that people living in the home had gone on a trip to Blackpool earlier in the year and another trip was being organised to go to Chester Zoo although we were told the activities coordinator had paid for the tickets personally and as people were moving out of the home there would be tickets left over and they were not sure how they would be reimbursed. Singers also came into the home every two weeks.

An activities folder was kept in the communal area which had a plan of activities for people living in that area of the home. The plans were detailed and contained information about the person's hobbies and interests before they moved into the home. One plan we read described how staff aimed to take the person on more adventurous trips, join local groups and engage them back in community life.

Records we saw of the daily activities the person engaged in did not show these aims had been achieved and the activities were mostly recorded as watching television.

The home employed an activities coordinator but during our inspection they were working in the office and at times had to work as a care worker meaning they did not have time to engage in activities with people on a day to day basis. Care workers tried to engage people in activities but were only able to do so for short periods of time.

We acknowledge that although some improvements had been made by the activities coordinator, activity provision was ad-hoc and not person centred. The service remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care.

People's care records contained detailed information about the person. The records included a "this is me" document which was completed either by the person or a relative describing the person's life history and things that were important to them. The manager told us; "We have got everyone involved in the care planning. We have focused on documenting the little details that care workers do to support people. The care workers will tell the nurses what is wrong with the plan."

The home had a complaints policy pinned to the noticeboard in the entrance to the home. The policy explained how to make a formal complaint but contained no contact details and also didn't explain how people could escalate their complaint if they remained unhappy with how their complaint had been dealt with. People we spoke with told us they knew how to complain and said they would speak to staff if they weren't happy. Relatives of people living in the home confirmed they felt able to complain. One person we spoke with told us; "[The manager] is there if I need anything."

Complaints were logged and details of the issues raised, actions taken to investigate the complaint and when these actions were complete were recorded. Where further action was necessary to resolve the complaint, this was also logged with a named person responsible for ensuring the actions were done.

At the time of our inspection no one was receiving care at the end of their life but the service had processes in place should people choose to remain in the home at the end of their life. We saw records indicating that decisions regarding whether people wished to be resuscitated had been discussed with people and their families and appropriate documentation explaining their decisions was stored at the front of the file so it was clearly visible and accessible for other healthcare professionals who may not know the person's wishes.

When we reviewed the medication arrangements in the home we found that appropriate arrangements for the storage and administration of medicines for people approaching the end of their life were in place.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection we found the service was in breach of Regulation 13 of the Care Quality Commission (Registration) Regulations 2009 as the financial stability of the service was not clear and of concern.

Prior to this inspection we received information from three nursing agencies who had supplied staff to the home. They advised us they were owed significant amounts of money and that they had not been able to contact the provider. We spoke to a representative from one of the agencies who told us a significant amount of money was owed to them and that they and a number of other agencies now refused to supply the home with staff.

We also received whistleblowing concerns that staff were not being paid their full wages on time and during our inspection we saw this had been raised by staff during supervisions. During our inspection the staff were again not paid in full on their normal pay day and had instead received 70% of their wages. Members of staff we spoke with told us; "We were told it was because we were overstaffed then he [the provider] blames Tameside Council." Another member of staff told us; "We were relying on the money to buy school uniforms. We've had staff members be threatened with eviction because they haven't been paid." Another staff member told us; "I'm really not ok. We've got people who can't pay their rent now."

Staff in the home were employed by a different company. This company although not owned by the provider was operated by a member of the provider's family. Shortly before our inspection we identified that this company was subject to a winding up petition from Her Majesty's Revenue and Customs (HMRC) which was dismissed as the amount owing to HMRC was paid prior to the hearing. Following our inspection, the provider explained staff in the home were agency staff. It is unclear what staffing arrangements the home will have if the agency they currently use ceases to trade as other agencies are unwilling to supply staff. Since our inspection a further winding up petition from HMRC has been served on this company.

There was a lack of the investment by the provider to address the shortcomings identified in previous inspections.

The financial viability of the service to carry on its regulated activities remains a concern and the service continues to be in breach of Regulation 13 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection we found the service was in breach of Regulation 19 of the Care Quality Commission (Registration) Regulations 2009 as there were unpaid fees owed to CQC. At the time of this inspection these fees remain unpaid.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The service had a manager who had been in post since September 2017 and at the time of our inspection was in the process of applying to become the registered manager of the service for the new

provider. Shortly after our inspection the application to change the provider was withdrawn and the manager could therefore not progress their application and the home remained without a registered manager.

Staff told us the manager had made a positive difference to the home. One care worker we spoke with told us; "There's not big things just lots of little improvements like how we record what care we have given to people that have made things better." Relatives we spoke with also gave us examples of improvements. One person we spoke with said; "They do little things that are within their power."

Following our last inspection, the provider informed us they undertook monthly visits to the home to engage with residents and relatives to discuss their views, however people we spoke with during our inspection said they had not seen the provider apart from a meeting held a few weeks prior to the inspection. One relative told us; "We never see him, that was the first time we saw him. We saw his son a couple of times." We asked staff whether they saw the provider or knew how to contact him if they needed to. One member of staff told us; "We see him now and again. It can be months and months before he comes and when he does he doesn't speak to us."

The governance framework in place to monitor and review the safety and quality of the service did not demonstrate the provider understood their regulatory responsibilities. During our inspection in December 2017 and January 2018 we identified areas of maintenance and repair to the home that needed to be completed to ensure the safety of people living there. During this inspection we found this work remained outstanding.

The quality checks that had been put in place since our last inspection were inadequate and had failed to remedy the concerns raised at our last inspection. Issues relating to the excessive hot water temperatures, window restrictors and other maintenance requirements in the home had not been identified by these checks. There was no guidance for staff to explain what was being checked or how it should be checked.

We asked to see audits or quality improvement activity relating to medicines. The manager showed us weekly medication audits, the last of which had been carried out in August 2018. This audit identified out of date medicines, medicines unaccounted for, incorrect doses of medicines administered, and gaps in administration records. We were told the clinical lead checked these audits to ensure they were completed correctly and discussed the findings with staff. However, when shortfalls were identified, there was no recorded outcome or action plan to drive forward improvements. This meant the provider could not demonstrate that audit findings were used effectively to improve quality and safety of medicines management.

We saw records of two Registered Person's Quality Monitoring Visits from February and May 2018. These identified numerous actions that needed to be taken, however very few actions had changed from the February to May reports and many of these remained outstanding by the time of our inspection.

The above demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Good governance.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 13 Registration Regulations 2009 Financial position except health service bodies and local authorities<br><br>Employment agencies have told us they are owed over £100000 by the home. |

**The enforcement action we took:**

We have cancelled the registration of the service provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 19 Registration Regulations 2009 Fees<br><br>Fees in excess of £40000 are owed to CQC. |

**The enforcement action we took:**

We have cancelled the registration of the service provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Activities provided in the home were limited and did not reflect people's hobbies or interests. |

**The enforcement action we took:**

We have cancelled the registration of the service provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Numerous health and safety issues identified during our previous inspection had not been addressed. These included fire safety, hot water temperatures and electrical safety works. |

**The enforcement action we took:**

We have cancelled the registration of the service provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Little improvement was seen in the breaches identified during the last inspection. Quality measures that had been put in place were inadequate. |

**The enforcement action we took:**

We have cancelled the registration of the service provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Appropriate employment checks were not being conducted in line with Schedule 3 of the regulations. Records did not always contain staff's employment histories and where there were histories, gaps in employment had not been explored. |

**The enforcement action we took:**

We have cancelled the registration of the service provider.