Chivrose Healthcare Limited

Brackley Lodge Nursing Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection which was conducted on the 13, 22 and 24 April 2015.

Brackley Lodge Nursing Home provides nursing and personal care for up to 30 people for people with physical disability, dementia and care for adults over 65 yrs. At the time our inspection began there were 21 people living at the home; however following the unexpected death of one of the people who lived there 20 people remained for the rest of the inspection.

The service is required to have a registered manager; the current registered manager left the service on 8 April 2015, just prior to this inspection. A registered manager is a person who has registered with the Care Quality

Summary of findings

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.' The provider has employed an acting manager and is in the process of recruiting to the registered mangers post.

Since December 2014 there has been escalation of safeguarding concerns at the home and a number of changes have been made within the staff team. This has destabilised the staffing and managerial arrangements in place and has impacted in the quality and safety of care provided.

People were not being protected from abuse. Staff recruitment process were not sufficiently robust and people were being cared for by staff who did not understand their needs and who did not have the competencies, training or guidance to care for them safely. Safeguarding processes were in need of strengthening and staff did not consistently understand their role and responsibilities to protect people. Reasons for injuries and bruising were not always understood and notifications to the relevant authorities were not consistently happening. Medicines were not always being safely or appropriately managed. Risk was not continually assessed and management strategies were ineffective in ensuring that peoples' safety was consistently maintained.

People were not being cared for in an effective manner. Staff did not always receive an induction and were not supported through adequate training, support or direction. Manual handling practice was particularly poor and exposed people to unnecessary risk. People's nutritional needs were not always known and staff were not always offering people support to eat and drink enough. The systems to monitor and respond to people's health and welfare were inadequate and staff were not always responding appropriately to their changing needs or in an emergency.

People's dignity and respect was not adequately protected. Personal hygiene and appropriate clothing was not always assured and some people were not being bathed or showered for long periods of time. Routines were task orientated and people's needs, risk or care requirements had not been continually reviewed. Care plans and assessments were out of date and were unable to guide staff in the provision of care. Staff were not always able to communicate with people and did not always take care to involve them or seek their consent for the care that was being offered. Mental Capacity and Deprivation of Liberty Safeguards were not consistently considered.

The leadership, quality monitoring and governance arrangements had collapsed and needed to be re-established. Records were not readily available, audits had not been completed for some time and previous audits had not been supported by action plans to drive improvement. There was an absence of day to day clinical and managerial leadership and the delivery of care was chaotic and disorganised.

The provider took a range of actions following our inspection and is working with an external management consultancy company to support the improvement in the home. They have stopped admissions into the home and have agreed to ensure that there is a registered general nurse on duty at all times.

We identified a number of areas where the provider was in breach of Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end to this report the action we have asked them to take.

The overall rating for this provider is 'Inadequate'. This means that it 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

Summary of findings

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. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Staff recruitment was not robust and staff deployment did not consistently ensure that there were sufficient numbers of staff on duty with the appropriate skills, experience or qualifications.

There had been be an escalation in safeguarding concerns at the home and the processes to protect people were not understood or followed by all staff.

Risk was not continually assessed and management strategies were ineffective in ensuring that peoples' safety was consistently maintained.

Medicines were not safely managed and covert administration of medicine was happening without the necessary assessments, authorisation and guidance.

Is the service effective?

Inadequate

The service was not effective

People were being cared for by a staff team which had not consistently received a sufficiently robust induction, training or guidance to ensure that they were enabled to care for people effectively. Manual handling practice in the home was poor and people were noted to have unexplained injuries and bruising.

Not all staff could communicate with people living in the home and some were not aware of their specific care and support needs. People's health and well-being was not appropriately monitored and their nutritional needs were not always being met. Staff did not always recognise or respond when people needed support or comfort.

People were not consistently consulted or involved in decisions about the way they were cared for and Mental Capacity and Deprivation of Liberty Safeguards were not routinely considered.

Is the service caring?

Inadequate

The service was not caring

People were not consistently cared for in a manner which protected their dignity and which ensured that their personal hygiene, clothing and continence needs were always attended to and appropriate.

Care plans and support was task focused and the care in which care was managed did not always take into account peoples' preferences and choices.

Some staff showed care and kindness to people.

Is the service responsive?

Inadequate

The service was not responsive

Summary of findings

People received inconsistent and at times unsafe care. Assessments and care plans had not been reviewed or updated and the staff team did not know the specific care or support needs of people living in the home.

Systems to support people to raise a concern or make a complaint were unclear and there were no records to confirm how complaints had been managed. The acting manager was responding to relatives concerns and was trying to address issues as they arose.

Staff did not have a picture of people's likes, dislikes, hobbies and interests. However there were some activities available which were enjoyed by people in the home.

Is the service well-led?

Inadequate 

The service was not well led.

There was no registered manager in post and the acting manager had only recently taken up their post and was not yet familiar with the home, the staff or the people receiving care.

The quality assurance and governance systems had collapsed, audits had not been undertaken for some time and action had not been taken to ensure that the standards of care were in line with expectations

The staff team were relatively new or were agency staff and they were not receiving the guidance, leadership and support they needed to ensure that they provided consistent and safe care.

The provider was visible in the home and people found them approachable

Brackley Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 13, 22 and 24 April 2015 and was unannounced. The inspection team comprised an inspection manager, three inspectors and an expert by experience with personal experience of caring for someone who used dementia care services.

In planning for our inspection we reviewed the information that we held about the service, including notifications from the service about things that happened in the home and information provided by some of the staff that worked there.

We also contacted Heathwatch Northamptonshire; Healthwatch Northamptonshire works to help local people get the best out of their local health and social care services. We contacted the Nene Clinical Commissioning Group (NCCG). Clinical Commissioning Groups are groups of GPs who are responsible for designing local health services in England. They do this by commissioning or buying health and care services for Northamptonshire. We contacted Northamptonshire County Council Commissioners and the Safeguarding Team.

Many of the people living at Brackley Lodge were unable to recall their experiences or express their views; however we attempted to speak with all of the people living there and we observed the care they received and the interactions of staff. During our inspection we talked with 20 people who used the service, two relatives and friends or other visitors, we spoke with two visiting GPs and we interviewed 22 staff who were both agency and permanent staff.

We looked at 12 peoples' records to check whether their needs were being met, we also looked at all 20 of the medicine administration records, all of the 2015 accident records and all of staff recruitment records. We made observations about the service and the way that care was provided. We also used the Short Observational Framework Inspection (SOFI); SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People living in the home told us that they felt safe in the home. One person said "Yes I do feel safe here and I have my say. My daughter would soon pick things up if needed." A relative said "My wife is safe as possibly she can be, but never 100%." However the views people expressed were not consistent with our inspection findings.

- We found that people were not always protected from abuse. Since December 2014 there has been an escalation in safeguarding concerns in relation to the quality and safety of care within the home and in relation to the conduct of some staff members. These matters are subject to ongoing investigations by relevant authorities however we found that the systems in place to protect people in the home had not been reviewed or strengthened in light of these allegations.

During our inspection we found that the home was being predominately staffed by newly employed or agency staff. The procedural and operational framework to support these staff was fragmented and confused and staff did not have ready access to policies or guidance on how to safeguard people in the home or to direct them about what to do if they had a concern.

Although agency staff told us that they had received training through the agency and that they understood the principles of how to safeguard people, they had not received any guidance on how to apply this within the home. We found that permanent staff were unclear about their roles and responsibilities in protecting people from abuse. Although two staff told said that that they would refer any concerns to the manager none of the staff were able to tell us the different types of abuse or any of the external agencies involved in the safeguarding of adults. Training records showed that only one of the four permanent care staff had received any training in safeguarding.

At the time of the inspection we observed that people had unexplained bruising and injuries, records and staff were inconsistent about how these injuries had occurred. These injuries had not been recognised as potential signs of rough handling or inappropriate care. Referrals to the Northampton County Council (NCC) safeguarding team or notification to CQC had not occurred.

We found that for some people, elements of their care needs were being disregarded; we observed that some people were not having their nutritional needs met and had lost weight, people at risk of pressure area care were not being appropriately cared for and the way in people were being supported through manual handling by staff were being exposed to ongoing risk and harm. CQC made ten referrals to Northamptonshire County Council Safeguarding Team as a result of this inspection.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

People were not consistently protected through the effective assessment, identification and management of risks to their health and safety when their care and support needs were being met. A relative told us "On Saturday and generally at weekends there's no manager. It's quite traumatic and disorganised. My wife had a tear to her left shin and a bruise below it. It looked like it could have been done with the wheelchair footplate. I spoke to the nurse and they didn't know anything about it. They put some solution on it."

Accident records identified that at least three people had unexplained bruising resulting from movement and handling techniques and equipment between 13 April and 20 April 2015. We saw three people with unexplained bruising and one person also had a head wound. Although the head wound was recorded in the accident records the staff were unable to provide us with the relevant daily records to show if this person's injury was followed up at regular intervals afterwards. We also noted that this person had an injury to their forearm; staff were unable to provide us with any record of this injury either in the accident book or the daily records. We also saw two other people with unexplained bruising to their forearms and wrists. People were assisted to move from chairs to wheelchairs with the use of unsafe moving and handling practices, such as underarm drag lifts on at least three occasions. Staff used unsafe procedures to move four people using the hoists; staff used the same sling to move them regardless of their weight and build. People were not supported appropriately by the sling and they were at risk of falling out of it; the sling also placed unsafe pressure on vulnerable parts of the body, such as under the arms and around the ribs. People did not have access to their own personal sling which

exposed them to the risk of cross infection. The hoist was operated by staff members; however the staff did not inform or reassure the person concerned during the process. We looked at the Individual plans of care which contained basic movement and handling plans, however they did not contain any reference to the type and size of the sling to be used or the maintenance of the hygiene for the slings. The Movement and handling plans had not been updated since February 2015.

We also saw that staff used a wheelchair to move one person; this wheel chair was used without the use of foot plates. There were no risk assessments or care plans in this person's individual plans of care regarding the use of the wheelchair and staff were unaware of the risk of injury in using a wheelchair in this way. Subsequently we saw this person at the dining room table, however whenever they leant forward the wheelchair slipped backward. We asked staff to check the brakes were on, however they told us that they brakes did not work. This put this person at further risk of harm.

Three people had recurrent falls in the period between February and March 2015, only one of these had been referred to the GP and none of them had been referred to the local NHS falls prevention service. There were no records after February 2015 to show that people had been checked at regular intervals after a fall or injury in case of delayed signs or symptoms of injury such as a fracture. People were assessed for the risks associated with falls from the bed and the use of bedrails, such as entrapment and injury; bedrail protectors were also in use. However the risk assessments had not been updated since February 2015, to ensure that they continued to be needed and remained safe to use.

Basic risk assessments for injury to the skin due to the effects of pressure on the body were in place; however these had not been reviewed since February 2015. People at risk had access to pressure relieving mattresses and wheelchair cushions. However when they were transferred to an armchair the pressure relieving cushion was not always transferred with them, this put people at risk of developing pressure ulcers to vulnerable parts of the body. Staff had recorded that two people had pressure ulcers in January 2015, there were no wound care plans for these pressure ulcers and no reference to them in the daily records in April; however agency staff told us that they thought these ulcers had healed and at present there was no-one with a pressure ulcer at the home. We discussed our concerns with a representative of the Nene Clinical Commissioning Group who confirmed that they were monitoring the wound care for people at risk.

We were concerned to find that the emergency equipment was not readily available. The thermometer was stored in a different part of the building to the disposable caps required to use it. The suction machine was stored in a locked room, there was no suitable suction tubing readily available to use with the suction machine. This placed people at risk of not receiving prompt medical attention as equipment for suction during emergencies was not readily available and ready for use.

People who had diabetes were not adequately cared for as staff did not regularly monitor their blood glucose. The care records did not hold any information to guide staff on people's acceptable blood glucose levels; there was no guidance for staff to take action where blood glucose levels were higher or lower than the normal range.

This was a breach of Regulation 12, (1) (a, b & e): Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

The systems to ensure adequate staffing levels were chaotic. There had been significant changes within the staff team and this has impacted upon the quality, consistency and safety of care provided to people living in the home. Some staff had left the service and some have been placed under suspension or dismissed pending the outcome of safeguarding investigations. This meant that people were being cared for by a staff team that was either relatively new in their post or were agency staff.

The acting manager and the provider confirmed that they were reviewing the staffing arrangements in place. They were aware of a significant risk in relation to the number of staff who could not adequately communicate in English and said that they were not sure why the previous manager had employed them into these roles. They acknowledged our concerns about one specific member of staff and the impact that their lack of English posed to the home, due to the role they fulfilled. The provider told us that they were currently recruiting for a permanent manager and five care staff.

The provider did not have a system in place to review the needs of people who used the service and to calculate staffing levels according to those assessed needs. Neither

the provider nor the acting manager could provide us with an accurate profile of the number of staff working in the home or whether the staff were employed by the service or by an agency.

The arrangements for registered nurse cover and deployment in the home had not been carefully considered. We found that the acting manager and the provider were unaware of whether the nurses on the rota were general trained or mental health trained nurses. In addition the nurse registration status with the Nursing and Midwifery Council (NMC) had not consistently been checked to confirm that they were still registered to work in this capacity. On checking we found that a nurse who was thought by the management to be a general nurse was in fact a mental health nurse and at least one nurse who did not have documentation to prove that they held an active registration. The provider and the acting manager confirmed that nurses registration status had not been verified, however following CQCs prompting they subsequently acquired proof that the nurse had an active registration.

On 8 April 2015 the Nene Clinical Commissioning Group required the home to have a registered general nurse (RGN) on shift at all times. This was in response to concerns about the adequacy of clinical care within the home. Although the provider had agreed to this action we found that there was not always a RGN on duty and this impacted under the clinical leadership and oversight of people's physical health care needs. For example; nutritional assessments, wound care and catheter care. On the 22 April 2015 we asked the acting manager to supply us with a copy of the duty rota for the subsequent two weeks; however they were unable to do this because it had not yet been done. When we revisited the home on 24 April 2015, the manager had not created the duty rota for the week commencing 27 April 2015. We were concerned about this because of the impact that the short notice could have on the availability of the staff, including access to registered general nurses and agency staff.

This was a breach of Regulation 12 (1) (c): Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

Recruitment systems were inadequate. We reviewed the 18 staff files available and found that these were in a chaotic state and did not contain the required information. Three of the permanent staff did not have any staff files or documentation to show that their recruitment had been completed appropriately. Staff references had not been obtained for example there was only one reference on file for the acting manager and three other permanent staff did not have the required number of references on file. Four staff who were also listed on the duty rota did not have Disclosure and Barring Service (DBS) checks on file and one member of staff had a CRB relating to a previous employer. None of the staff files contained a job description that specified the work that the person was employed to perform.

We identified that seven of the staff listed on the duty rota were agency staff. However the provider had not checked with the agency to ensure that staff had the required qualifications, recruitment checks and training before they were allowed to work in the home.

The provider had failed to ensure adequate registered general nurse cover to provide the required clinical leadership in the home. On checking we found that a nurse who was thought by the management to be a general nurse was in fact a mental health nurse and at least one nurse did not have documentation to prove that they held an active registration with the Nursing and Midwifery Council (NMC). In addition the nurses registration status had not consistently been checked to confirm that they were still registered to work in this capacity. The provider and the acting manager confirmed that nurse's registration status had not been verified, however following CQCs prompting they subsequently acquired proof that the nurse had an active registration.

This was a breach of Regulation 10: Fit and proper persons employed. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

Medicines in day to day use were stored appropriately. Medicines that had a short life were not always clearly labelled with the dates of when they were first opened. We reviewed 20 Medicine Administration Records (MAR); each person had a photograph for identification purposes and the MAR had been signed by nursing staff when they had given medication and when they had not, there was a clear indication why. Staff had recorded most people's allergies on the MAR charts; one person had no record of any allergies recorded in any of their care records, putting them at risk of receiving medication which they may be allergic to.

Inadequate

Is the service safe?

We observed a medicine round being undertaken and saw that medicine had been pre-dispensed into unlabelled pots for two people who were in receipt of covert medication. The nurse told us the medicines had been pre-dispensed and put to one side earlier so that they could be added to people's food. We found two instances where people were being administered their medicines 'covertly'. This means the medicine was being given to them in food or drink without their consent.

Appropriate arrangements were not in place in relation to administering medicine covertly; there were no appropriate assessments, authorisations or pharmaceutical guidance. There were no other records in the individual plans of care or elsewhere to show that a Mental Capacity assessment and associated best interest decision had been made to provide medicines covertly. There was no written evidence from the GP to confirm that this person was to have their medicines added to food.

There was a risk that the medicines would not be effective as they had not been given as the pharmacist had advised. One care plan dated September 2014 stated that that the pharmacist had advised that the liquid medicine and tablets could be crushed and dispersed in water, however, we observed that the medication had been added to their food and hot tea. There was no instruction as to how the medicine in capsule format was to be managed.

People receiving covert medication were at risk of not receiving all of their prescribed medication. We observed that one person had their medication added to the butter in their bacon sandwich. We observed that they ate only half of the sandwich and refused to eat any more as they said "The bacon tasted sour". The staff did not encourage the person to eat any more; the person may not have eaten their food because the flavour was adversely affected.

People were at risk of having medication that was not prescribed for them. The care records for one person stated that they were on a reducing diet, however, staff had identified that the person would finish off other people's food and required supervision to prevent them from doing so. One person who had covert medication had left half of a bacon sandwich containing covert medication; the sandwich was left on the plate on the dining table and the people were not supervised, there was a risk that the person on a reducing diet could have consumed the bacon sandwich containing the covert medication.

We discussed our concerns with the management consultant employed to work with the provider to improving the running of the home. They said that stock control was poor and that there were medicines stored in cupboards that were no longer in use or were out of date; these should have been returned to the pharmacy or safely disposed of. This excess medicine included controlled drugs; the management had allocated a named nurse to review all aspects of the medicine management systems however this had not been completed at the time of our visit. The medicine policies had not been updated and needed to be revised; staff also needed to be trained to ensure that they understand and are able to follow these in practice.

This was a breach of Regulation 12, (2) (g): Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

Inadequate

Is the service effective?

Our findings

One person said "I get on with the staff pretty well but there's such an unsettlement here at the moment with the staff, half of them don't know what to do. The staff seem to be here two or three days then you don't see them again. There are usually one or two that can't speak English very well. There's usually one that can speak English, they are usually quite helpful when you've got through to them what you really want."

Staff did not have the knowledge or skill to meet people's needs. None of the staff files contained any information about the induction of new or agency staff. Staff confirmed that they had not had an induction period and that they were learning from each other. The recently appointed acting manager told us he had spent two days with the previous registered manager to learn about the running of the home. The agency nurse who was working on the day shifts told us that they had come in for two hours before their first shift to find out about the needs of people living there and information about the location. However we found that not all agency staff had spent time in the home before they commenced working their first shift.

One of the recently appointed domestic staff was unable to speak any English; they were unable to tell us anything about their recruitment or if they had received any induction training; or training in infection control, health and safety or the control of substances hazardous to health. There were no records to show whether any of this training had been provided. We saw the management consultant endeavouring to communicate the risks associated with wet floors and to restrict the amount of fluid used to reduce the risks of slips and falls. Another member of the domestic staff had been in post for six weeks and had received no training, including food safety from the provider

There was very limited training information available in relation to the permanent staff and only a very brief outline of previous training was available for agency staff. There was no up to date training matrix or plan available and the management consultant stated that all staff need to start from scratch to re-establish training baseline and ensure competence. One member of staff said "The training here is lacking. People are starting on shift without doing moving and handling [training]." This lack of training and competence was placing people at risk due to poor manual handling techniques. Inspectors observed staff using under arm and under leg lifts to move people, this was raised with the acting manager. On our second visit we observed staff using hoists to move people, however they were not using slings which were appropriate to the individual and this placed them at significant risk of falling from the sling or receiving other injuries whilst being moved. We noted that one person had a dressing on their arm and staff stated that the person arm had been caught on the sling the previous day.

We raised our concerns with acting manager and the provider and asked that immediate action be taken to ensure people were kept safe when being assisted to move. We also referred our concerns to the NCC Safeguarding team. The provider had arranged for external experts to carry out manual handling assessments and to urgently update the staff training. The external experts reported that there were significant concerns about the lack of staff competence in movement and handling which needed to be addressed as a matter of urgency.

Many of the people who lived at the home were limited in their ability to recall or express their views about the service so we spent time observing the way staff cared for people. We found that staff lacked the ability and skills needed to understand peoples' needs and provide appropriate care for people. One person was calling from the 'quiet lounge', staff did not respond and inspectors had to ask one of the staff to assist them. Staff had limited ability to communicate with people due to their poor English language skills. During the inspection we witnessed people becoming increasingly frustrated as they tried to gain assistance from the staff; for example one person became unsettled and distressed after their visitor left. Staff failed to notice this or to support the person concerned until they were significantly more distressed and unsettled. Staff were unable to communicate effectively or to distract the person towards some of the activities that were going on in the home. On another occasion a person wished to leave the dining room table, however staff did not offer them the support they needed and told the person that they would be with them, "In two seconds" however they stated this several times and this caused the person to become increasingly frustrated. During one of these incidents we observed one member of staff to be distracted by both the television and their personal mobile phone.

Inadequate

Is the service effective?

This was a breach of Regulation 18: Staffing Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

Staff and the acting manager did not fully understand their responsibilities in relation to the assessment of people under the Mental Capacity Act 2005 and the in relation to the Deprivation of Liberty Safeguards (DoLS). There was little evidence that people were given the opportunity to be involved in decisions about the way in which their day to day care needs were met. We observed that staff provided support to people with very little explanation or consent. For example one person was brought into the lounge in a wheel chair and just left without any explanation and we saw that generally movement and handling manoeuvres were conducted without seeking the persons consent and without any explanation of what was happening to the person. Individual plans of care contained little information about how consent was to be obtained or for what purpose.

We also found that medicines were being administered covertly to two people; they had not had Mental Capacity Assessments and associated best interest decisions; in addition there was not always evidence that the person or their family had been involved in these decisions. In one case we saw that a relative had secured a 'Lasting Power of Attorney' and had agreed for medicines to be given by staff and for the use of bedrails. However there was no evidence that any best interest decisions had been made or that any authorisations for deprivation of liberty had been sought from the local authority. We concluded that people's rights were not protected and their freedom may have been restricted. We referred our concerns to the NCC Safeguarding team.

We found other aspects of care where consent had not been appropriately sought. We noted that some people had an advanced decision 'Do not attempt resuscitation' (DNAR) form in their files signed by the GP. However there was no evidence that these had been discussed with the individual concerned or that 'Best Interest Meetings', had been held to ensure that the decision was in the best interests of the person concerned. We found that these decisions had not been reviewed by the date specified and we were concerned that in the event of a medical emergency people were at risk of inappropriate treatment. This was a particular concern as in a recent incident staff had been unable to locate the DNAR and were unaware the persons views in relation to this intervention. This is subject to an ongoing safeguarding investigation.

This was a breach of Regulation 11: Consent - Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3).

There was not a clear or consistent understanding of peoples' nutritional needs, although basic assessments were on file these were not readily accessible to staff and the care plans were vague in this regard. Intake was not consistently monitored and weight loss was not swiftly identified and addressed. The acting manager confirmed that there was a need to complete MUST (Malnutrition universal screening tool) assessments, to fully assess people and to identify those at risk of not eating or drinking enough. They said that "People at risk of losing weight were not being monitored and that fluid and food intake was not being monitored". They confirmed that they had asked for all people to be weighed on a regular basis and that this had happened over the preceding weekend. However at the time of our inspection we found that little action had been taken to improve this area of peoples' care.

Staff and the acting manager were not able to readily identify people with conditions such as diabetes and did not know whether people needed a specific diet; for example sugar free or soft diets. Three people who had been identified as having sustained significant weight loss, however there had been no action taken to increase monitoring of these people or to refer them to the GP or the dietician. Food and fluid records were not being adequately maintained, totalled or monitored. We saw that according to records some people had taken very little (less than 500mls of fluid a day for three occasions in one week), however there was no evidence that the reasons had been explored or that staff were asked to take any specific action in this regard.

It was a significant concern that risk assessments for difficulty in swallowing or choking were not in place. Where people were prescribed fluid thickener for their drinks, there was no instructions and staff were not aware who required thickened fluids to aid their swallowing. We also found that people who are allergic to food were not protected from harm; where people were prescribed medication to be given in an emergency for an allergic reaction, the staff could not locate the medication and staff

were unaware of people's food allergies. We observed two mealtimes, and saw that staff collected meals from the serving hatch and gave them to people without checking that the food was intended for them. There was a risk that people could get food that was the wrong consistency, contains sugar or they were allergic to.

During the first day of our inspection fifteen people were assisted to the dining room for their lunch from 12:30 onwards. After 15 minutes some people were still waiting to be served and one person was heard to say "Come on I'm hungry." Some people had to wait up to 45 minutes for the staff to assist them to eat their meals, by which time their meals were cold. We saw a kitchen staff prompt an agency staff to assist this person to eat and saw that although they spoke with them they didn't help them to eat anything. The person and their food were left for some time and we had to intervene when we saw their food was about to be removed without the person being offered any further assistance to eat. This person's care plan said they should be assisted to eat.

Peoples' individual plans of care and food records showed that although breakfast times were flexible the lunch was usually served to everyone from 12:30 onwards, followed by the evening meal from 4:30 pm onwards. This put people at risk of having a gap of up to 15 hours between their evening meal and their breakfast. There was no fruit or other snacks around the home that people could help themselves to. Food records showed that people sometimes had 'a handful of sweets or a couple of biscuits at 9 – 10 pm but this was not routinely available.

This was a breach of Regulation 14: Meeting nutritional and hydration needs - Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3).

We saw that GPs were called out to people when staff recognised that this is necessary, However we found that the clinical oversight of peoples health and welfare needs was inadequate and was exposing them to unnecessary risk. We found that there were no baseline observations recorded for any of the service users and staff did not have an indication of what observations would be normal for each person. There was no evidence to demonstrate that people's well-being was routinely monitored through the use of observations such as temperature, pulse and blood pressure. We also found people had not had timely referrals to specialist services such as the falls prevention service or the dietician when assessed or seen as being at increased risk.

Peoples' clinical well-being was not reviewed or acted upon. For example we found people with unexplained injuries that had not been referred for medical attention and there was no evidence of action taken where people experienced weight loss or gain. For people who were diabetic there was no evidence to confirm that blood glucose levels were being regulatory monitored or to confirm action taken when these readings were higher or lower than expected. Peoples' fluid intake and output was not adequately monitored Following a recent incident (which is subject to an ongoing safeguarding investigation) there are concerns about staff awareness of emergency procedures and their ability to seek medical advice and respond appropriately in a medical emergency.

This was a breach of Regulation 9 (3) (c): Person-centred care - Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3).

We concluded that the current staff team did not have the skills or competencies to safely and effectively monitor the health and wellbeing of people in the home, and that they did not recognise the significance of monitoring observations, weight loss or gain and fluid intake and output. This was placing people at risk of heath related complications. We discussed our concerns with the provider and they agreed to ensure that there was at least one registered general nurse on duty at all times.

This was a breach of Regulation 18: Staffing Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

Inadequate

Is the service caring?

Our findings

People were not supported to maintain their privacy and dignity. On the first day of our inspection people appeared dishevelled; several people looked as though they lacked basic care and attention. Their hair was unkempt, their eyes, mouths and finger nails were also dirty. In some cases their clothing was stained and poorly maintained.

One person told us "I don't have a shower as often as I'd like. I had one last Friday night and I probably won't get one for another week. It's about once a week if you're lucky. I've gone up to three weeks without one. I don't like to keep running after them, asking them. I've had one late at night with the night staff to get one. I can't use it myself you see. I'd like a shower at least once a week." Records showed that this person had not had a shower or bath for three weeks earlier in the year. A member of staff said "We plan for each person to have a shower or bath every week but that does not always happen and staff don't always record it if people refuse."

A relative said "They are supposed to shower and wash my wife's her hair before the hairdresser visits. The hairdresser phoned me this week to say her hair had not been washed. This has happened two or three times now. I have told them her hair isn't looking fresh. They say they use dry shampoo sometimes; and "This morning my wife had a vest on and a cardigan, she did not have a blouse on. I've raised this several times." This relative went on to tell us that sometimes this had not only impacted on her dignity but also her privacy because her chest had been exposed.

Another person told us "I called the staff in this morning as they are storing a lot of products in my wife's wardrobe which aren't hers. I asked them to move them off her shoes. We found her slippers underneath which were caked with food. She deserves better."

A relative also said "I'm not sure that they [staff] are taking people to the toilet before lunch. On Saturday I heard someone say 'someone' is having a wee on the dining room floor. Staff said "People do have to wait to go to the toilet often. This is when staff are assisting others with their personal care".

We concluded that people views were not respected nor were they supported to maintain their dignity.

This was a breach of Regulation 10: Dignity and respect Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3).

Care and support in the home was task focused rather than person centred. When we visited the service at 06:30 on the second day of our inspection several people were already up and dressed. Although several people still had unwanted facial hair they appeared to be better groomed than at our earlier visit and were dressed in smart, clean clothing. However at least one person told us that they did not wish to be up so early in the morning. The night staff told us that they routinely got people up to help the day staff, and two other people to take their medication. However we could not establish if this was what other people really wanted as they were unable to express their needs and it was not included within their individual plans of care.

One person said "I have full choice and a say in how I spend my time and how I am cared for". However there were limited opportunities for people to provide their views about the service, we saw people become frustrated when trying to express their needs and communicate with staff. There was no evidence that people were given the opportunity to participate in the development and review of their care plans as these had not been kept up to date. The management team were unable to tell us when they had last sought the views of the people living there or their relatives.

People were addressed by their preferred name and we saw some acts of kindness; particularly from the existing staff who had established relationships with the people living there. For example one person told us it was the anniversary of her husband's death recently and a staff member brought her in a lovely bunch of flowers to remember the day, she found this very touching and the flowers were nicely displayed in her room. We also saw staff gently persuade a gentleman to have something to eat and drink, when he did not want to go into the dining room; they left him for a while and when they went back he readily went with them.

One resident said that there had been a lot of staff changes and that this could be a bit disruptive but that they were very happy with the care staff. This person said "They come and visit me and they are very attentive. They know I have problems sleeping and they check on me to make sure I am ok".

Inadequate

Is the service responsive?

Our findings

People were being exposed to the risk of receiving unsafe and inconsistent care. Since December 2014 there had been significant changes within the managerial and staffing arrangements in place and this had impacted upon the way in which care and support was being provided. The current staff team were relatively new in post or were agency staff; most members of the staff did not have an understanding of people's needs, likes and life style preferences. The assessment and care planning processes were inaccurate and had not been updated to help staff understand people's needs and how these were to be met.

The individual plans of care that we reviewed contained very little information about people's previous lives. This information is particularly necessary when people are living with dementia; the life history should provide staff with information about the people who are important to them and enable staff to engage in meaningful ways relevant to the persons' past life experiences. Without this information staff may be unable to understand people's preferences and behaviours.

Record keeping systems had not been maintained and it was difficult to get a picture of who lived in the home, what their current needs were and to identify any associated risk factors. During our inspection the acting manager was unable to readily identify the needs of people in the home, they were initially unable to confirm who was in receipt of nursing care, who were diabetic or if anyone in the home had any other specific care needs. They had not yet carried out any recent assessment or reviews of care and staff were acting on instinct in relation to how they were supporting people. For example some of the day staff started work at 7:00hrs before receiving any information from the night staff about people's well-being and any changes required to meet their needs. The handover was at 08:00hrs and comprised only a basic verbal summary of the care provided and there was also a pre-printed sheet which contained information about peoples dietary and mobility needs and the numbers of care staff required to meet those needs. However there were inaccurate and based on out of date information.

Assessments and care plans that were in place had not been updated and were inaccurate. The arrangements for involving people or their representatives in their own care were chaotic. There was very little evidence to demonstrate that people were able to be involved in the planning and review of their individual plans of care. A relative told us they had come in for a meeting to review the individual plans of care last week but the manager had left and the meeting did not go ahead. Another person said they had a letter about a meeting to review the individual plans of care on 17th April 2015 but the new manager didn't know anything about it.

This was a breach of Regulation 9 (3) (a) (b) (d): Person-centred care - Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3).

The management were unable to provide us with any information regarding complaints received by the home. However one person told us "They look into complaints but it's not always possible to put it right. They have a repair man to come in but you sometimes have to wait. He's good when he's here." People told us that the acting manager was addressing things that they had brought to his attention and the acting manager confirmed that they had been busy trying to rebuild relationships and was focused on sorting out peoples' concerns. However in the midst of all the recent activity they had not had time to record or maintain records of the issues they had dealt with or the action they had taken.

One relative said "If there are any concerns about my family member the staff call me, but there is no major drama." However another relative told us they were not always kept updated about the wellbeing of their loved one, for example about the injuries they had sustained. However people told us visiting times were flexible, one person said they had lots of visitors and we saw that visitors were coming and going freely during our inspection.

People were supported to maintain links with family and friends. A relative said "I was given the opportunity to have a meal with my wife." Another person said "There are not too many activities but I wouldn't want any more, as I go out with my daughter."

We saw there was an activities programme for people to participate in if they wished, people engaged in gardening activities, physical ball games and musical sessions during our inspection. These sessions appeared to be much enjoyed and some activities were also happening on a one to one basis. One person also told us that the "The activity lady has just been in to play cards with me, which I love". We also saw that some people had been supported to

Inadequate

Is the service responsive?

maintain their faith; one person told us “I’m C of E and I went to church on Easter Sunday. My church is a long way away, but they do a service here on the 3rd Wednesday of the month.” One person told us they had an entertainer coming in on one night and that he was ‘good’.

Inadequate

Is the service well-led?

Our findings

At the time of this inspection the registered manager had recently (8 April 2015) left their post and was no longer working in the home. They had given short notice to the provider and although there was an acting manager in post, they had only been working in the home for just over two weeks and had not had an induction into this role. They had very little knowledge about the needs of people in the home, the staff group or the managerial and leadership requirements of the home.

The provider had organised for a managerial consultancy company to help support the acting manager and the home as a whole. The consultant allocated to the home had commenced two days prior to this inspection and was in the process of working with the deputy manager to prioritise and plan the improvement action that was required.

The acting manager and the consultant were not able to provide the inspection team with a picture of the needs of people living in the home at the time of the inspection. This information was not readily available to them and the chaotic nature of the records meant that they were struggling to establish the range of people's needs in the home. They were initially unclear how many people had nursing care needs, which people needed pressure ulcer care, whether anyone in the home was diabetic or needed any specific care or support.

The acting manager was responding to concerns and information that was being brought to their attention. Relatives told us that where they had raised matters with the acting manager that they had responded really quickly to address the issue and to reassure them that they were taking action to ensure the safe care of their loved ones.

Although the previous registered manager had conducted some internal audits, records showed that these had not been completed since February 2015. Where these audits had identified an issue, there was no action plan or evidence of follow up to confirm that this had been addressed. The last audit of peoples' individual plans of care had identified the need to ensure the DNAR forms were reviewed and collected from one person's doctor. There was no evidence that this had happened and a recent incident in the home had exposed confusion and a lack of records within the home in relation to this aspect of peoples' care. The management consultant said that they would ensure that this was followed up immediately. The acting manager and the management consultant were unable to confirm when the last fire audit had been completed and there were no records that could be located to help clarify this. They therefore agreed to organise an updated assessment in this regard. We notified the fire safety officer about the lack of fire safety provision.

The acting manager had not had the opportunity to proactively consider or fully assess the current risk and key development needs of the service. They stated "Everything I have looked at, has not been up to date or was completed a long time ago" and went on to say "I have not had the time to put things in place as I have concentrated on care issues and reacting to the issues people have raised with me".

One person said "It is a terrible service here, they are short of staff, the management don't say anything to us about what is happening." The management team were unable to provide us with any evidence that meetings had been held with people who used the service or their relatives. However an action point from the strategy meeting was for the provider to call a meeting for the people who used the service and their representatives to update them about the management of the home, staffing levels and the future plans for the service.

The acting manager and the provider had recently held a staff meeting to update staff on what was happening in the home and to ensure they felt supported. They told us that the "staff morale is low, it is getting a bit better now, but the staff feel anxious about the future". Systems relating to record keeping and data management were not robust because records required to ensure people were cared for safely were incomplete, inadequate and inaccurate. For example nutritional records were not completed; the assessments were inaccurate and were not reviewed to identify concerns. There were no management systems in place to recognise the implications and risks associated with the data.

The records in place for monies held on behalf of people were generally well maintained and corresponded to the money in the purse being held. However there were some discrepancies and the records and the money available differed; in one case there was £20.00 missing. Neither the acting manager nor the provider had audited the monies recently and left the management of this to an

Inadequate

Is the service well-led?

administrator. The acting manager contacted us the following day to tell us that they had identified the cause of the error and that the balance was now consistent with the records.

The staff team consisted predominately of new or agency staff and arrangements to support, train and development them were not in place and this needed to be urgently addressed. At the time of our inspection the clinical and day to day leadership of care was ad hoc and inconsistent. It was apparent that this new staff group had no leadership and we saw that this was impacting on the quality, consistency and safety of care provided and on the experiences of people in the home. The policy framework in place had not been reviewed or updated for some time and was not being referred to guide staff or to help in the management of the home.

Quality assurance systems had broken down. The arrangements for staff supervision had lapsed, and this was affecting staff morale; one staff member said "I don't really feel very supported." And another said 'I'm not really supported. We're not a proper team as we don't have permanent staff."

The provider was visible in the home and was known by the people living in the home and their relatives; they felt that the provider was accessible and always available for a chat. One relative said "[the provider] is a really nice man, he is always here, and he talks to us and to my relative, he is very caring".

Discussion with the provider highlighted that they had relied on the previous registered manager to update them on the service development needs and that they had believed that things were progressing relatively well. The provider told us that since the registered manager had left that they were surprised by the extent of the things that needed to be addressed in the home. "This has been a real lesson learnt for me, I relied on the manager and thought things were ok, I can see that I need to keep a much tighter grip on things". Following our feedback the provider formally notified us that they will ensure there is a registered general nurse on every shift and that they would not admit any new people to use the service until improvements have been made and compliance with Regulations has been achieved.

All of the above represents a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Peoples' clinical well-being was not reviewed or acted upon and people were being exposed to the risk of receiving unsafe and inconsistent care. **Regulation 9 (1)(a)(b)(c)(3)(a)(b)(c)(d)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's views were not respected nor were they supported to maintain their dignity. **Regulation 10(1)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's consent to care and treatment was not always sought and the management and staff failed to act in accordance with the Mental Capacity Act 2005. **Regulation 11(1) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse because staff did not understand the different types of abuse,

This section is primarily information for the provider

Action we have told the provider to take

how to recognise it, or how to report it; or have ready access to policies or guidance on how to safeguard people in the home or to direct them about what to do if they had a concern.

Regulation 13 (1) (2) & (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Peoples' nutritional and hydration needs were not met. **Regulation 14 (1)(4)(a)(b)(d)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The management of the home was chaotic and quality assurance systems had broken down. Record and data management systems were not robust and people were at risk of unsafe care. **Regulation 17 (1) (2)(3)(a)(b)(c)(f)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent and experienced persons deployed in order to meet peoples' needs. **Regulation 18 (1) (2)(a) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Action we have told the provider to take

Staff recruitment systems did not ensure that fit and proper persons were employed.

Regulation 19 (1)(a)(b)(c)(3)(a)(4)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided to people in a safe way.** **The management of medicines was not safe or proper.** **Regulation 12, (1) (a, b, c, e & i) 12, (2) (g)**

The enforcement action we took:
We issued the provider with a warning notice to ensure that people receive safe care and treatment.