West Berkshire Council

Birchwood

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

Summary of findings

Overall summary

This inspection was completed on 29th September and 1st October 2017, and was responsive in relation to a number of concerns and safeguarding issues received by the CQC.

The service was taken over by West Berkshire County Council on 1st June 2017, prior to which the care was provided by a corporate service provider. Some of the staff were transferred as part of the acquisition; however senior management within the service was lost.

Birchwood is a 60 bed service that provides facilities over three floors to older adults with varying needs. The ground floor provides a respite service for up to ten people undergoing an assessment period when transitioning from hospital or home and prior to an appropriate care package being sought. The first floor provides residential services to a maximum of 25 people. The second floor provides nursing care to a maximum of 25 people. People's needs varied depending on their diagnosis. We found some people required extensive support whilst others were able to complete some tasks independently.

A registered manager had been in post since the service was taken over by the local authority. 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.

Notifications had not been made to the CQC for all incidents that were considered safeguarding alerts or reportable as a serious injury. This is a requirement of the registration regulations.

People were not kept safe. Risk assessments and comprehensive documentation was not in place to ensure people were offered responsive safe care and treatment. Care plans contained minimal information, often leaving out crucial information. For example, one care plan did not document how frequently a person required assistance with personal care. This meant they were at risk of their basic needs not being met and increased the potential of the person's skin being damaged.

Medicines were not managed safely. During a medicine round we observed the medicine trolley was left unlocked and unattended for a brief period of time. A person was witnessed approaching the trolley. MAR charts were completed and errors were noted. However guidelines had not been written for all people who were prescribed medicines to be taken 'as required'.

Fire safety checks were being completed and recorded. However people were not being kept safe at all times due to a failure in appropriate monitoring and recording of other health and safety checks. Not everyone living or staying at Birchwood had a current personal evacuation plan in place, although staff did have access to one page colour coded list that them who was independent and who needed assistance. Water temperatures checks were not being carried out as required, leading to concerns that staff would be

unaware if a thermostatic valve stopped working, putting people at risk of scalding.

Staff did not appropriately record information. Incidents were not reported, and information was not accurately updated in daily records. We noted that one person had sores on both legs, without any dressings. Staff told us that dressings had been removed by the person. No alternative dressing had been applied. Records did not note that the person had sores on legs, what dressing should be applied or how the sores were to be managed.

Staff had not received supervision, or had a team meeting that allowed them to gain an understanding of the provider's values and vision since taking over.

Neither the provider nor the registered manager had effective systems in place to assess, monitor and improve the quality of the service. There was also no system to assess, monitor and mitigate risks to people using the service, their visitors and staff.
Staff generally were polite and respectful in their approach to people. However much of their role appeared to be task orientated. There were sufficient staff on duty who had received training to support them in their roles. However there were times of the day when staff deployment needed to be considered. The organisation of staff meant that they were not always effective and people's needs were not being met in a timely way and this, at times, left people unsafe.

During the inspection we identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by the 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.
• Services placed in special measures will be inspected again within six months.
• The service will be kept under review and if needed could be escalated to urgent enforcement action

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.

Risks were neither assessed nor were measures implemented to keep people safe.

Medicines were not managed safely. Guidelines for all 'as required' medicines had not been completed, nor were medicines always secure during the medicine round.

People were not safeguarded from abuse. Measures had not been implemented to appropriately investigate and monitor reported incidents.

Staff were not deployed to floors appropriately, leading to safety issues for people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive supervision or have team meetings to support them in completing their roles.

It was unclear if people's nutritional or hydration needs were always being met, due to poor documentation.

The service was not designed appropriately to fully meet the needs of people living with dementia.

Consent was sought from people.

Is the service caring?

Requires Improvement

The service was generally caring.

People were spoken to, and seen to be treated with kindness. However many tasks completed by staff appeared to be 'task led' and not person centred.

Privacy and dignity was protected, with doors being appropriately closed during personal care.

Records were not always maintained confidentially.

Is the service responsive?

Inadequate

The service was not responsive.

Peoples care plans were not reflective of their changing needs.

People did not always have all of their personal care needs met.

Appropriate alternative measures had not been put into place to manage and respond to people's needs as and when these arose.

Complaints were not appropriately managed or recorded.

Is the service well-led?

Inadequate

The service was not well led.

Staff, families and professionals found the management unapproachable.

No effective processes were in place to monitor the accuracy of the provided care.

Audits had not been completed to identify where improvements were needed in relation to service documentation.

The service did not comply with alerting CQC of safeguarding or other notifiable events.

The principles of duty of candour had not been completed.

Birchwood

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 29 September and 1 October 2017 and was an unannounced responsive inspection. Day one of the inspection was completed by one inspector and an inspection manager with the second day completed by one inspector.

The Care Quality Commission (CQC) received intelligence prior to the inspection of concerns relating to the service that required further investigation. Issues were related to poor management, failure to report and respond to concerns, an increase in safeguarding issues, some of which were not reported to the CQC and an increase in the use of agency staff. We spoke with the local authority safeguarding team and the quality monitoring team seeking feedback. CQC attended an organisational safeguarding strategy meeting on 22 September 2017 that further highlighted concerns. This meeting included staff from various departments within the local authority, including, reviewing, complaints, safeguarding and quality monitoring.

Due to the service having only just been registered with CQC, and the nature of the inspection being responsive, a Provider Information Return (PIR) was neither requested nor completed. The PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We requested local authority reports and action plans, as well as a comprehensive chronology of CQ1s. These are care quality concerns that fall short of the safeguarding criteria, however, are of significance and if left unresolved can qualify as safeguarding over time.

During the inspection we spoke with eight members of staff, including the registered manager, one registered nurse, the occupational therapist, a senior care officer, a care officer and three care staff. We spoke with three people who use the service and eight relatives of people who were authorised to speak with us on their behalf. In addition we spoke with four professionals from the local authority. We employed the Short observational Framework for Inspection (SOFI) over lunchtime on both days of the inspection. The SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We further made general observations throughout both days of the inspection, including a medicine round.

Records related to people's support packages were seen for 10 people. In addition, we looked at a sample of records relating to the management of the service. We were unable to view records related to staff recruitment as these were maintained off site. However, as most of the staff that were permanent had come through an acquisition process, their files had been previously checked under a different provider.

Inadequate

Is the service safe?

Our findings

CQC received intelligence from external sources, including professionals, staff and family members raising concerns for the safety of the people residing at the service. This prompted a responsive inspection to establish the validity of the concerns. Issues that had specifically been raised included people being put at risk, due to poor documentation and recording systems, concerns around medicine management, staff deployment, infection control and potential abuse.

People were not always being kept safe at the service. Whilst the risks were not imminent, they were consistently present in different aspects of the care provision. This led to serious concerns related to people's safety. One relative we spoke with reported that whilst he felt that his relative was safe, he was concerned that there was no paper trail, therefore was unsure how safe people truly were. One professional stated, "We do not have evidence that people are safe." We were unable to see any documentary evidence of risk assessments having been completed for people residing at the location. Neither generic risks associated with older adult services, such as risk of falls, urinary tract infections or skin integrity, nor specific risks e.g. catheter care, epilepsy or mental health issues were available. A risk assessment is a document that aims to provide details on how to manage behaviours or concerns that may identify as risks for people. The assessment should detail when the risk is more likely to occur, and consider measures that can be implemented to minimise the onset of these risks. The majority of the people who use the service are at threat of multiple risks. It is therefore crucial that staff are aware of how to manage these risks, as the impact can be significant for people. For example, we looked at the file for one person who did not communicate verbally; they also had limited mobility and were incontinent. There was no documentation for staff to follow to ensure that the person's needs were known to all staff and that these needs were appropriately met. Their complex needs increased the probability of developing skin problems. The lack of documentation for these risks meant that staff may not be fully aware of the most appropriate way to manage the risk, or that a risk actually exists. The person was unable to verbally communicate their needs to staff. This risk was further increased by the number of agency staff employed who did not know the resident well.

It was unclear if any incidents had occurred as a result of the absence of documentation, as records were not maintained appropriately by staff. This meant that incidents related to people were not being appropriately recorded, monitored or analysed in order to prevent a similar occurrence. Monthly log books were created for each person to document daily records. Staff were required to make handwritten notes in these booklets during each shift. Body maps, skin integrity checks and records pertinent to people's health e.g. weight were required to be noted where they were applicable. However, we found that staff were not appropriately keeping a record of these. For example, we saw on day two of the inspection one person had sores on both their shins. The person was repeatedly rubbing these. We spoke with the staff on shift, and were told that the sores had previously been dressed but the person had removed the dressing. We queried why an alternative dressing had not been applied and were not given a response. We checked the person's daily notes and found that no record had been made of the dressing being applied or removed. There were two recordings on the body map. These were dated 3 September and 15 September, they detailed an injury to a hand/arm and one on the left shin. There were no subsequent recordings. This meant that there was no

record of how the wound occurred, how it should be treated and what other appropriate action needed to be taken such as referring to a nurse or GP. There was no evidence the person's wound was being appropriately cared for. The fact that dressings had been removed and the person was rubbing the wounds put them at possible risk of infection.

In another example staff spoke with us about an incident where a person had entered another person's room, and had pulled over a wardrobe. We asked when this incident occurred and were told "in the last month". We checked the records for the person and could not locate anything detailing the incident. We spoke with the registered manager regarding this, and were told that this had not been reported to them. However, they were aware of a similar incident where a bookshelf had been pulled over. Records for both the person whose room was entered and the person who walked in, particularly for the bookshelf incident were checked. No record could be found. This meant that incidents related to people were not being appropriately recorded, monitored or analysed. The registered manager acknowledged that the risk for injury was present in this example, and further appreciated that documenting incidents was essential.

We case tracked 10 people, looking at their files in relation to their needs. We also reviewed their medicines, and daily records. For one person we observed that they required two to one assistance with all position changes, as they were immobile. This person would often call out for staff to "help". We saw that this person was in bed for most of the day on day one of the inspection. It was 11.30am on day one and they had not yet received their morning personal care, which meant that they were in their nightclothes and it was not known if they had received person care that morning. We spoke with the staff who advised that the person was "next on the list" to have personal care completed. We reiterated that they had been calling out, and were told that this was "what she does". We observed that as staff approached the room, the person declined assistance. We reviewed the person's file to see how staff were advised to approach the person in order to be able to assist them while causing the least amount of anxiety. We found that the person's file did not contain a care plan. There was no guidance of what morning routine the person liked to follow, how they liked things done or how staff should approach the person if they were feeling anxious and so declining assistance. Of more concern we were told that the person required a full body hoist to reposition. There was no information about this in their file. There was no guidance for staff about which hoist and sling should be used and how it should be used. This put the person at significant risk of being moved inappropriately. We spoke with staff to establish if this had been misplaced, or was perhaps located elsewhere. We established no care plan had been written.

We reviewed the person's medicine folder and found that they were prescribed PRN (as required) medicines, specifically to help with sleep. We checked to see what guidance was available and found that no protocol was in place to tell staff when this medicine should be given. There was no information for staff to follow to ensure that the medicine was always given appropriately, for example what might prompt its administration or guidance to ensure that it was not given too late which may cause the person to sleep through the day. We could not be sure that the person was always given their medicines appropriately. In correct usage may result in potential medicinal restraint or over use of medicines. We checked six other folders for PRN guidance and found that these were in place for pain relief, specifically paracetamol. We spoke with the registered nurse on shift and the registered manager, who assured us that the guidance for the sleeping tablet would be written up immediately. We asked the RGN if any other forms of PRN were given except for paracetamol, and were told no.

On day two of the inspection we observed a medicine round. Medicines were kept securely in a medicine trolley that was stored in a temperature controlled medicine room per floor. This was removed during medicine rounds. On both the ground floor and second floor of the service the registered nurse (RGN) was responsible for administering all medicines. On the first floor this was the responsibility of the senior

registered care officer (SRCO). Our observation was completed on the second floor. The RGN stationed the trolley outside each person's room, unlocked it and dispensed the person's medicines into a pot to take to them. We found that the RGN was preparing medicines for two people simultaneously, cross referencing these against the medication administration record (MAR sheet). We observed the RGN then left the trolley unlocked and open outside the person's room while they went in to give the person their medicines. One person who walks in the corridors, often entering people's rooms when not kept occupied or busy, accessed the open trolley. At this point we intervened. The RGN simultaneously came out of the person's room and the person was prevented from taking anything from the trolley. We spoke with the RGN about safe medicine management, and subsequently the registered manager. The service advised they would be taking action to address this.

We also received intelligence prior to the inspection which referred to the premises being unclean. One incident reported by a family member specifically referred to a soiled chair that had been left in this condition in a communal bathroom. During our inspection we found that the premises were generally kept clean, we did not find a soiled chair or anything else that was unclean in the communal bathrooms. A housekeeper was employed specifically for this role, however it was expected that staff would clean up after an incident if the housekeeper was not available. One family member we spoke with raised concerns with us regarding poor infection control. We were told that several incidents had occurred when a person had entered their relative's en-suite, and used the toilet. Faeces had been smeared on the toilet, wash basin and wall. The relative stated that "it can't be [name] as he is immobile". We were told that the staff had not noticed that a person had entered someone else's room and defecated in the bathroom, this had been left dirty for unknown periods of time. The relative told us they had cleaned the bathroom.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the people were always kept safe. The provider had not done all that was necessary to mitigate any such risks related to the safe administration of medicines or preventing and detecting the spread of infections.

Staff spoken to during the inspection were able to describe different types of abuse; however, they were not confident that this would always be reported to the appropriate authorities. We were told that where applicable staff would not hesitate to whistle-blow. Part of the pre-inspection intelligence was gained through staff whistle-blowing. This raised specific issues around safeguarding concerns not being reported appropriately to CQC or the local authority. As part of the notifications procedure, any concerns pertaining to safeguarding or serious injury are required to be promptly reported to CQC. Failure to do so can result in a breach of regulations. We found that we had not been kept abreast of a number of reportable incidents. The registered manager had failed to inform CQC of these issues as and when they arose. We spoke with the registered manager regarding this, and were assured that all incidents would be reported in retrospect. The local authority advised that they had been contacted by various professionals and family members regarding witnessing of issues that met the criteria of safeguarding. Although families told us these had been raised with the registered manager they felt they had not been appropriately investigated. For example, it was reported that a person was force-fed medication by an RGN. This had not been reported as a safeguarding incident of abuse. This meant that the allegation had not been appropriately investigated although the registered manager had spoken to the agency from which the RGN had been contracted through. Another person was reported to have sustained a fractured arm; it was unclear how this injury occurred. The registered manager had neither reported this as potential abuse, nor informed CQC of the incident as a serious injury. It remains unclear how the injury was sustained or similar injuries could be prevented because no documented investigation was completed. Therefore the potential for recurrence remains.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the service did not fully understand its duties to safeguard or appropriately investigate abuse.

We noted that staffing numbers generally appeared adequate across the service. However issues around deployment were observed. There was a high agency staff usage, of approximately 55% per week, which potentially led to issues around consistent delivery of care. There was a recruitment drive in process to ensure a skilled workforce was employed, however, this was in its infancy. We noted that staff deployment was not always appropriately managed. For example, during an observed lunch period on the second floor we noted that staff were stood in the dining room waiting for food to be plated up. We observed that for approximately 15 minutes they stood without interacting with any resident, while watching another member of staff try to assist two people to eat at the same time. At this point in time there were sufficient staff on duty, however they had not been deployed in an efficient or effective way. Another example was the timing of the start of the night shift and the tasks they needed to complete. The night shift commenced at 8pm. Staffing levels on the first and second floor equated to either one RGN or RCO plus two care staff. Their duties included serving drinks and sandwiches, completing personal care and administering night time medicines. A number of people required two staff to assist them with personal care, leaving one member of staff on the floor. However, this person would often have the responsibility to administer medicines. One RGN told us of their fear of medication errors. This was due to the responsibility of overseeing so many people while also giving people their medicines. We were told that whilst managing medicines, if colleagues were engaged in delivering personal care they would have to ensure the people who liked to walk were safe. We were told of incidents when people have tried to take medicines from the RGN's hand or speak with the RGN whilst they were cross referencing medicines. One incident was relayed to us, in which a person repeatedly pulled at the RGN, whilst they were trying to administer medicines. They had to stop the task and re-direct the person because there were no other staff available. We spoke with the registered manager regarding this serious concern. They agreed that the daily routine or staff cover at that period of time needed to be reviewed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the service did not appropriately deploy staff to be able to carry out their duties safely and effectively.

Requires Improvement

Is the service effective?

Our findings

People were cared for by a staff team that had received training to help support them with their role. Records showed when training was due to expire for staff and highlighted what training they had received under the previous provider. The registered manager had not compared the existing training matrix with the training the local authority perceived as mandatory. Training such as moving and positioning, first aid, safeguarding and person centred care had been completed by all permanent staff. Specialist training including dementia, epilepsy awareness and catheter care had not been completed and team of staff were offering support to people specifically with these needs. The registered manager advised that he would be looking at specialist training for staff, and would develop a training matrix that highlighted what training the service required. We were provided with a copy of this information post inspection. The training would be delivered internally by the local authority, and as required by an external provider, if appropriate.

Staff reported that they had not received supervisions since the provider had taken over the service, and that no supervisions had been arranged to date. Supervisions are 1:1 meetings that are provided by a line manager to staff. We queried whether the registered manager observed any of their practice and gave them an opportunity to raise any issues or addressed any observations. We were told that they knew they could speak to the registered manager, however no formal procedure had been implemented. We spoke with the registered manager on how staff were being supported and were told they were in the process of rolling out a supervision programme. Although the permanent staff had received training, the registered manager had not completed any competency assessments to establish their skill and knowledge level. Whilst staff reported that they had not attended meetings, we saw evidence that meetings had occurred on 11 occasions. Nine of these meetings had been with the senior staff team and two included the care staff team. On one occasion – 26th July 2017 four care staff attended. The second meeting of 20th September 2017 had three care staff in attendance. It is therefore important to note, that meetings have been arranged by the provider and registered manager, however they had not been successful at engaging all the care staff The registered manager recognised that the lack of support mechanisms meant that staff did not feel valued or able to do their jobs effectively.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which stipulates that staff should be competent, skilled and experienced to carry out the tasks needed, with appropriate support and training.

People were cared for by a staff team that had a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). All staff employed had received training in the MCA, as this was perceived as mandatory training. The 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. We found that DoLS applications had been requested as required by the registered manager. This included urgent application for people who were residing on the

ground floor in transition.

People reported that staff sought consent before completing personal care, although from observation staff were task focused. They said, "They do help, but it's very quick". Another person said, "They ask, but sometimes don't wait for an answer. It's all very quick, but they are rushed off their feet." We spoke with the registered manager about this and queried whether sufficient staff were employed per floor. We noted that the ground floor had a significantly higher staffing ratio, than either the first or second floor, although the number of people was considerably lower. The calculated numbers of staff on shift were adequate to assist people safely and effectively, however it was clear that they were not always in the right place at the right time. This was not corrected by the manager or any senior staff.

People received some effective health care and support. People were able to see the visiting GP and other health professionals such as Community Mental Health Teams as and when required. Existing contact sheets from the previous provider illustrated that specialists were consulted as required. These contact sheets continued to be updated with relevant information, however this had not always been translated into the care plan.

It was unclear from care plans when people required nutritional support. One person who found eating difficult had food purchased by the family. We spoke with their relative who advised us that "this way I know what she's eaten". From our observations, it appeared that people who required support with eating had this provided. We spoke briefly with one of the caterers who told us that the nurses updated them regularly on people's dietary needs. We also observed one person being served a pureed meal at lunch time, this was presented well. Drinks were provided with the meals, however not everyone was given a choice of what they would like to drink. Some people were just handed a glass of squash. There was an inconsistent staff approach to the meal time. Some staff were very engaging with people and offered them a choice of meal, presenting them with the two plates to allow them to choose. Others just placed a plate in front of the person. However people were asked if they had had sufficient and if they wanted a pudding. A choice of yoghurt was offered if the person did not want the pudding that had been prepared.

The second floor offers specialist care in dementia, although people on any floor may live with dementia. We found that whilst this floor was geared towards dementia, bedrooms appeared de-personalised; memory boxes outside bedroom doors had little or no items within them. Signage although used, was positioned too high on the wall for most people using the service to be able to read or see clearly. In one case the signage had fallen off a communal bathroom but had not been replaced. Toilet seats for communal facilities were not colour coded, which could prevent possible mishaps. We noted on day one that a person entered one of the communal toilets and urinated on the floor. Staff were unaware of this until we bought it to their attention when another person tried to enter the toilet. Staff told us that this person would "often do this". They were aware that this was likely to happen but had taken no steps to lessen the possibility or react quickly when it did. The lounge did not lend itself to providing a comfortable, familiar dementia friendly environment. Seats were arranged along the perimeters, heightening the potential for poor socialisation for people when not being engaged by the activities coordinator or generally by staff. Some appeared isolated when sat within a communal setting. The corridors offered little information of interest. We found one seat had been placed in one of the corridors allowing a person to sit and reminisce, although no additional activity was available. The home was generally not making relevant alterations to accommodate the changing needs of people and there was no evidence of guidance on best practice for people living with dementia having been sought.

We would recommend that the service seek advice and guidance from a reputable source with regard to appropriate training for staff. Specifically in relation to dementia care and dementia friendly environments.

Requires Improvement

Is the service caring?

Our findings

During our inspection we observed some very caring interactions between staff and residents. We also observed staff being 'task led' which did not demonstrate care. Staff were able to correctly describe how they would preserve people's dignity when assisting them with personal care. Staff told us they would knock or call out to the person before entering the room, and explain what task they were going to complete. They would check that the person was okay with this before proceeding. In one instance, a person did not want to receive personal care. Staff gave the person space, before trying again, gently coaxing them. When personal care was being delivered, the door was closed, and where appropriate curtains drawn and the person covered. One person we spoke with confirmed that staff did take the necessary steps to maintain their dignity.

An observation was completed during both days of the inspection on both the first and second floor during lunchtimes. On the second floor we focused on five people, three of whom required support with eating. The staff who were assisting mainly offered task focused support. At one time a member of staff was trying to assist two people with eating at the same time. We observed little or no communication between staff and people. People were not asked before being offered a mouthful of food, nor were they asked what they wanted to eat, for example, the vegetables or the meat. There was very little social interaction, the period was not a pleasant and enjoyable experience. Some people sat for the entire lunch time period without speaking to or interacting with any one with the exception of being offered their meal.

On the first floor, we noted that one person had his food cut up without him agreeing to this. He was asked but staff did not wait for his response. When the food had been cut, he looked at it and said "now that doesn't look very nice". The member of staff smiled and offered the person alternative food. On both floors we noted that staff that were in the dining room waiting to take food to people in their rooms, stood silently, although did occasionally smile. We noted that one person on the first floor was rather vocal towards other people. Their mannerism was being perceived by three other people as threatening, with one retaliating and threatening them with "you'll get as good as you give", whilst another asked the person to remain quiet. Although staff were present, no one intervened to de-escalate the situation. This continued for approximately six minutes, after which a senior registered care officer (SRCO) entered the room, redirecting one of the people.

Families of people reported that staff were caring towards their relatives. This was observed over the course of the two day inspection. Staff were seen treating people with kindness and approaching them with care. For example, we found that when one person was becoming distressed during the day, a permanent registered nurse offered them reassurance. They sat with the person until they became settled, talking to them and using diversion techniques to change their train of thought. They smiled throughout the interaction and used touch appropriately as reassurance. One relative told us of concerns regarding one agency worker who was on shift on day two of the inspection. They told us that they had observed the worker over several days as being "rude to people and residents". They had not raised this with management, although had considered approaching the staff directly. We brought this to the attention of the member of staff leading the shift on the floor, and were reassured that they would speak with the agency

worker.

One relative we approached spoke very highly about the care their relative received. Whilst another spoke of how staff had placed a birthday banner on their relative's door. This they felt showed how staff cared about their relative and highlighted how they tried to make people feel special. However, a common theme of discontent amongst families was clothing being misplaced or relative's wearing other people's garments. We spoke with the registered manager about this and were advised that they were aware of the issues. The housekeeper had requested that all clothes be labelled so as to minimise the potential of items being placed in wrong rooms.

Relatives told us they had not been directly consulted about their family member's care plans. Although communication had commenced between the home and relatives recently, some relatives spoken with did not feel involved. We were told that the service did not provide adequate information and explanation of why certain changes had been implemented and that this was concerning some people and their families. A general worry from families was there may be were ramifications from speaking with us. We spoke about how the service listened to people and their families with the registered manager. They told us that people should feel they could raise any concern but acknowledged that perhaps communication between them and the families could be improved.

In general people's right to confidentiality was maintained. We found that staff spoke with respect and privacy regarding people. They would go to an empty room (e.g. dining room or lounge), office or stand to the side of the corridor and speak in a low tone when discussing people so that the conversation could not be over heard. However, we found that the offices on both the first and second floor were left unlocked with some people's files left on the desk unattended. The cabinet containing access to the remainder of files was left unlocked. This was in contrast to the ground floor, where files were kept securely in the locked office. Daily record books for people were not kept in people's rooms, but in an unsecured cabinet in the communal lounge. This meant that anyone had access to potentially confidential and personal information. It further highlighted that staff may not be writing notes immediately after completing tasks or offering assistance. We spoke to the leading staff on shift and the registered manager regarding this, who reassured us that the cabinets would be secured.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's needs. Care plans had not been completed for all people using the service. The local authority had taken over the service on 1 June 2017, with completed care documents from the previous provider. The decision had been taken to implement new care documentation straight away rather than using and reviewing what already existed. However this action had not been completed for all people and those that had been completed did not contain sufficient information to allow people to be supported appropriately.

Care plans were inadequate and did not provide sufficient information to ensure that support met the needs of people. The service had chosen not to use the care plans that were left by the previous provider when delivering care, although retained these in the relevant offices. Instead, staff on each floor were given the responsibility of writing new documents. Staff reported difficulty accessing the new paperwork on the computer, therefore had to hand write information on printed sheets which were not large enough to contain all the relevant information. Staff did not fully understand what information needed to be documented within the care plan. The concerns were not regarding the format of the paperwork, but staff knowledge of what needed to be recorded within it. For example, where people required two staff to support them with repositioning, details were not given of which hoist or sling was to be used. In another example, the care plan did not document the frequency of supporting people who required assistance with incontinence. One relative reported that her husband had "soaked through the sheets to the pillows" as a result of staff not assisting him appropriately. She reported that he had been at this service for over five years and had never had an incident like this. The relative stated the paperwork was sparse and staff failed to record information. This had led her to believe that care was not always being delivered to meet her husband's needs. Another person had a diagnosis of type 2 diabetes. There was no information within their care plan on what this condition was and how it was to be managed. There was no guidance for staff on and how this person presented when their diabetes was not under control or what they needed to do about it. Uncontrolled diabetes could have serious ramifications on the person's health. The lack of documentation and guidance potentially put the person at risk of ill health.

We raised our concerns about this with the registered manager and the service manager. They advised that a full review of all documents would be completed by the end of October 2017. They agreed that people had been left vulnerable, as existing paperwork was not fit for purpose.

The care plans that had been written were not person centred. They contained minimal information and did not address how the person wished to be supported. Information appeared to be gathered from relatives and staff who had transitioned over from the previous provider, irrespective of whether the person was able to provide the necessary information themselves. For example one file viewed was for a person who had moved into the service in June. Due to their condition they had complex emotional needs which could lead to very anxious behaviour. There was no information in the care plan about the person or their preferred daily routine. There was nothing to inform staff of what they liked and what they didn't like. There was no guidance for staff about what made the person anxious or what could be done to relive their anxiety. We addressed this with the registered manager, who confirmed this would be looked at when reviews were

completed for all residents.

The service employed an activity co-ordinator. On the first day of the inspection we noted that a coffee morning in aid of Macmillan had been arranged on the first floor. Cakes and drinks were being sold to raise money for the charity. People on all floors were able to access the activity with assistance. We found that no other activity was offered during the day by the co-ordinator. The staff appeared unaware of how to engage people when not completing tasks. We made numerous observations during both days and found that specifically on the first and second floor staff appeared unaware of methods to engage people. For example, we saw on several occasions people seated along the perimeters of the communal lounge. The TV was on, but no one appeared to be watching it. People sat in chairs were either asleep or disengaged. Staff although present, remained silently seated. However, we noted that the deputy manager did engage with people. He was observed to be seated near people holding their hands whilst talking gently with them.

Some people were observed to be walking up and down in the corridors. There was little staff interaction and little available to keep occupy them or give them a focus. For instance, there were minimal reminiscence objects such as rummage boxes, clothes to try on or objects that might prompt a memory that people could be directed towards. In contrast the ground floor staff were seen to offer activities. For example, on day one we observed a game of musical bingo being played by people and staff. They appeared to enjoy this, singing songs and smiling with staff during the activity. We spoke with the registered manager about how activities and engagement was promoted. It was recognised that with the high volume of agency staff currently being used, the service was predominantly task focused. This meant that people's social needs were not always met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which identifies that the care and treatment must be appropriate to meet the needs and reflect their preferences of the person.

People and their families were aware of how to report a complaint or a concern, however were not confident that this was responded to appropriately. We found that neither the staff nor the registered manager appropriately recorded, reported or investigated complaints. We spoke with the registered manager about how these were handled, and were told that a team within the local authority took the lead. We accepted that this was the case for any concerns that were raised by people or families externally, but asked what procedure was in place for complaints raised directly to the home. The registered manager advised that no protocol had been developed for complaints made directly to the service. They stated no paperwork existed to demonstrate complaints had been referred to the Councils system or monitored and recorded internally. The service did not have or operate effectively an accessible system for receiving, recording and responding to complaints made directly to them.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that complaints must be investigated and proportionate action must be taken.

Inadequate

Is the service well-led?

Our findings

We found that the service did not have adequate management and leadership. Staff we spoke with raised concerns about the registered manager's ability to oversee the service. We were told that they had not been appropriately provided with information and are "expected to get on with it." This was mirrored by the feedback from professionals. They told us they were, "Not confident" in the current management structure. At the time of the inspection a locum manager had been employed to transition the service. The locum manager was asked to take on the registered manager position until a permanent manager was recruited. The deputy manager, although consistent, was agency staff. Families reported the registered manager as being "initially unapproachable, although had warmed recently." Another relative stated the registered manager was "always in the office", whilst the deputy manager preferred to work with people on each of the floors.

We found that whilst staff knew how to provide care to people, accurate records were not maintained to show this. This was therefore neither reflective of good care nor did it illustrate how changes to people's needs were being managed. There was a risk that any new staff, including the high volume of agency staff working at the service could provide ineffective and inappropriate care, by following inadequate care plans. The registered manager was aware of the lack of detail available to staff. They were in the process of reviewing files and meeting with the families in order to update the care plans but this had not been completed.

We were told that audits of care files had not been completed since the service was acquired by the local authority, as the registered manager had not created the paperwork or had the time to complete this task. However the registered manager told us that medicine audits were completed monthly by the deputy manager. Upon inspection of the file, this was in fact an 'error report'. The deputy stated that an audit was completed but only the errors were noted. If there were no errors there was no record of the check. The deputy manager told us they investigated these errors however had not documented the outcome of the investigations. There was no evidence that required actions and learning had taken place to reduce the risk of recurrence. Neither the registered manager nor the deputy manager completed checks on the work of the clinical staff or completed internal audits of systems.

We were provided with maintenance records for a variety of weekly and monthly checks completed by the maintenance person. The registered manager had not audited the file and was therefore unaware that checks had not been recorded as being completed as required. For example there was no evidence that water temperature checks were being completed, although a document existed for the recordings to be documented on. We spoke with staff to determine how they ensured people were being bathed at safe temperatures, and were told they would check the water themselves. Asked where this information would be recorded, staff were unclear. We asked the registered manager where this needed to be detailed, however were not provided with a definitive answer, as they too were unclear. We found thermometers and water temperate sheets in bathrooms, however these contained no information. Likewise it was unclear if the maintenance man had completed these checks. This was a concern as should the thermostatic valves not be working, staff would potentially be unaware of this and thus place people at potential risk, by

immersing them in water that was too hot. If water temperatures are not adequately controlled and checked this also poses the risk of legionella bacteria causing potentially fatal infections.

Fire checks had been completed as appropriate. This included, fire equipment checks, panel checks, sounding the alarm and practice drills. Staff had access to a list of people which was colour coded to show who needed assistance and who was independent. This did not detail what sort of assistance and by how many people. Although personal emergency evacuation plans (PEEP) existed for people on the first and second floor, these had not been updated or reviewed since the local authority had taken over, there was a risk they were inaccurate. No PEEPs were written for people on the ground floor. It was therefore assumed that they would be able to exit the building as required should an emergency occur. This had not been appropriately assessed therefore potentially put some people at risk.

The service had a cleaning schedule in place. The housekeeper signed to indicate when each task had been completed. We found that the environment was generally kept clean. However, lifts are meant to be mopped daily, according to the cleaning schedule. This task had not been completed for over 20 days.
The registered manager was unaware of what routine tasks had and had not been completed. They did not complete a regular audit or have an overview of what had been completed and what needed to be done. There was no system to assess monitor or improve the quality and safety of the services. There was no system to assess, monitor and mitigate the risks relating the health, safety and welfare.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, that specifically focuses on good governance.

As part of regulations, services are required to notify CQC of any safeguarding or serious injury notifications. We found that the registered manager had failed to notify the CQC as and when safeguarding or serious injuries occurred. The local authority had brought to our attention a number of alerts and concerns identified by professionals and families around suspected abuse. Upon further investigation it was established that we had also not been notified of serious injury concerns. This means that CQC was not provided with information required by law and potentially impacts on the ability to perform its regulatory role.
This was a breach of Regulation 18 of the Registration Regulations 2009, which informs provider of those incidents that are notifiable to the CQC.

Some family members reported feeling more comfortable speaking with the new management over the last month. However they raised that there had been inconsistency with numerous changes in management policies, which they felt caused disruption to the service. Families reported they felt that the service still lacked good communication, and that minutes from meetings were not an accurate reflection of how they felt or what was said, however had not reported this to the service. All families reported that they felt the service was not transparent. One relative stated, "It feels as though things are hidden, or just not told because of the possible backlash from families." When a notifiable safety incident has occurred the provider must comply with the duty of candour. This legislation aims to ensure that the service is transparent and reports openly on care and treatment. It means that relevant people will be notified, an account of what is known of the incident must be given and consider further relevant enquires. It further reinforces the need to document investigations where appropriate, providing an apology when things go wrong. We found that the duty of candour had not been followed through in several incidents where people had sustained injury. The registered manager assured us that moving forward the duty of candour would be evidenced.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, that specifically focuses on the duty of candour.

It was clear that the service did not have clear vision or values that had been communicated to the staff, as they were unable to provide information on this when questioned. Staff generally felt they were able to speak to management and voice their opinions. Although would not approach either the registered or deputy manager for assistance when completing paperwork. We queried the reason behind this and were not given a response that explained the rationale behind this. It was apparent that there was misunderstanding and miscommunication around staff roles and responsibilities. For example, on the ground floor we found that neither the registered nurse (RGN) or the occupational therapist (OT) were willing to take the lead when care planning. Although the registered manager had an opinion on this, they did not appear to have appropriately managed the situation as issues remained prevalent. The OT perceived themselves as a professional who was coming into the service as a consultant. They therefore were supervised externally. No RGN had been recruited for the ground floor, therefore agency RGNs were being employed. The OT was systematic in their thinking that their role was to provide a service focused on promoting physical and mental well-being. However, had not considered how this could be incorporated into a general document for all staff (i.e. care plan).

It was recognised that the service was relatively new to the provider and the registered manager. However, it is important for the both provider and registered manager to have a thorough overview of the provision. The local authority had worked with the registered manager and provider to create an action plan, however it was apparent at the time of the inspection that the neither the provider nor the registered manager had a complete overview of the service's shortcomings. The registered manager was able to inform us of their plans and share some template documents that were to be used in order to assist staff to make changes.