Golden Age Management Limited

# Attwood's Manor Care Home

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

The inspection took place on the 6 and 7 July 2017 and was unannounced. The previous inspection had been undertaken on 8 February 2017 to follow up concerns found at the inspection in September 2016. The inspection in February 2017 found that there had been some improvements and the overall rating of the service changed from inadequate to requires improvement. At our inspection in July 2017 we found that the improvements made had not been sustained.

The provider continued not to provide a manager registered with the Care Quality Commission (CQC). The home had a manager who had been in day to day charge of the service for a significant period of time but they were not yet registered with the CQC. At the last inspection in February 2017 and at this inspection they told us their application was being processed. However we found no record of this being submitted. 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.

The premises were not well maintained and there were insufficient controls in place to mitigate risks. For example we found windows without restrictors and the risks regarding legionella were not being managed in a way that protected people. Individual risks to people had been identified but the management plan was not always followed by the staff supporting people. For example we identified issues with the use of moving and handling equipment, catheter care and the management of wounds.

Medicines were not managed safely and we did not have confidence in the auditing process as it had failed to identify some of the issues that we found such as people being given the incorrect amount of medication. We found that the stock did not tally with the records and creams and lotions were not being administered as prescribed.

There were systems in place to calculate the numbers of staff needed to meet people's needs but we found that the service was dependent on agency staff and staff were not always deployed effectively which meant that people did not receive care when they needed it. The service was in the process of recruiting new staff but the issues that we identified at the last inspection about the robustness of the process had not been addressed.

Staff received training but we were not assured about its effectiveness as staff knowledge in areas such as infection control and dementia did not reflect best practice. There was a system of induction for newly appointed staff but we found that new staff were working without sufficient guidance. Checks were not undertaken on staff competency and understanding of what they had learnt.

Some training had been provided on the Mental Capacity Act 2005 and consent. However staff

responsibilities were not well understood and the best interest decisions were not accessible or clearly documented within people's care plans.

Mealtimes were not well organised and people needed more support with eating and drinking. People's nutritional needs were assessed and where there were concerns referrals had been made to dieticians. However, the advice given was not always followed and greater monitoring and oversight of people's intake was needed.

Staff were well meaning and had good relationships with those they supported. However interactions were largely based around the completion of a task and staff did not always promote people's privacy and dignity. We were not assured that people always received care that took account of their wishes and what was important to them.

Care plans did not provide sufficient guidance to staff on people's needs. We identified gaps in how people's needs were monitored and had concerns that information was not always handed over which meant that issues were not addressed promptly. Documentation was not completed contemporaneously and as a result not always accurate.

Activities were provided to promote peoples wellbeing. There was a policy in place which set out how complaints should be managed however none were recorded as received which was contrary to what people told us. The policy was out of date and we could not see that complaints were used to drive improvement.

This service was operating well below the numbers of people for which it is registered. The local authority has been supporting the service to improve over a long period of time. They had placed a consultant within the service to support the improvements, the provider had continued to employ the consultant for a short period but had not continued with this support. It was a concern that the service has failed to sustain some of the improvements implemented with the support of the consultant.

Staff and people spoke positively about the manager and told us that they were assessable and helpful. There were some audits in place but they were not effective as they had not identified the shortfalls that we found. Overall we concluded that there was a lack of management oversight.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, they will be inspected again within six months.

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

or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe

Risks were not always identified and safely managed.

Medication was not managed in a safe way. Audits were not picking up the shortfalls in practice.

Staff were not always deployed effectively to meet people's needs.

There were systems in place to check on staff suitability prior to appointment but these were not robust.

Staff were aware of what was abuse and the actions they should take if they had safeguarding concerns.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff training was in place but staff were not always following best practice. The induction of new staff was not sufficiently robust.

People needed more support at meal times.

Staff had a limited understanding of the Mental Capacity Act.

People's health was monitored and they had access to a range of health professionals.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People's dignity was not always promoted.

Staff were well meaning and kind however we were not assured that people always received care which took account of their

wishes and what was important to them.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans were not sufficiently detailed and did not give the staff the information they needed. Information was not always acted on. The care records were not always accurate.

People had access to activities to promote their wellbeing.

Complaints were not used in a positive way to improve the quality of care.

## Is the service well-led?

**Inadequate**

The service was not always well led.

There was a manager in post but they had not applied to become registered. The staff and people using the service told us that they were approachable and supportive.

There were shortfalls in a range of areas and the homes management had not sustained some of the improvements that they had previously made.

Audits were not driving or sustaining improvement

# Attwood's Manor Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 6 and 7 July 2017 and was unannounced. The inspection team was made up of three inspectors, a pharmacist and a professional advisor. The professional advisor was a nurse with a background in the care of older people.

Before the inspection we used information we already held about the service including recent notifications which are important events services are required to tell us about. We looked at outcomes from safeguarding investigations, meetings with social services and feedback from other health care professionals.

As part of this inspection we carried out observations on the care provided. As a number of people who lived in the service were living with dementia we used the Short Observational Framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at records in relation to people's needs, the management of the service, maintenance, the recruitment, and training of the staff. We spoke with thirteen people, four relatives, eight care staff, five ancillary staff and the manager. We interviewed three visiting health professionals and viewed ten care plans. We looked at eleven peoples medicines and carried out a medication audit.

Inadequate

# Is the service safe?

## Our findings

People were not protected from the risks of unsafe care, because the premises were not suitably maintained and there were insufficient controls in place to mitigate the risks. Staff had a limited understanding of hazards that placed people at risk.

We found some parts of the environment presented risks to people and there was a lack of environmental risk assessments in place to guide staff on the steps they needed to take to protect people. There was a lack of effective controls in place to reduce the likelihood of harm. We found a number of rooms on the first floor of the service had no window restrictors in place. Window restrictors help to prevent vulnerable people falling from height and given the levels of dependency in the service, we asked for this to be addressed as a matter of urgency. The arrangements in place for the prevention of legionella were not satisfactory. There was no risk assessment in place and we found parts of the building were not in use. This was a concern because stagnant water encourages legionella growth and there was no system in place to flush infrequently used outlets. We asked the manager to urgently review the systems in place. Radiators were largely covered to protect people from the risk of burns but we found an exposed radiator in one of the toilets. There was a main staircases accessed via the communal entrance which was partly blocked by two chairs. There had been a stair gate on this but we were told that this was broken. The manager was not able to provide us with any assessment of risk regarding the risks posed by the accessible staircase. We observed a number of people who were disorientated walked around trying to access different parts of the service. We were told that there had been a previous injury sustained when an individual had fallen on the stairs.

Individual risks to people were assessed but management plans to mitigate the risks were not always consistently followed. A number of people required assistance to mobilise. There was widespread use of toileting slings which provides minimal support for people and we were not clear if they were always the most suitable and safe way of supporting people. One of the people we looked at had been assessed by the occupational therapist as requiring support of a universal type sling earlier this year. The occupational therapist had written that they needed, 'a general purpose sling with greater level of postural support, which did not position under the arms.' However we found that staff were using a toileting sling which was not suitable for their needs. Another care plan we looked at said that staff should use one size of sling in one section but a different size in another and we were concerned that this lack of clarity could lead to an accident.

We saw that the service was caring for two people who had a catheter. One person's care plan stated, "Ensure my catheter is emptied regularly and document how much urine is emptied when a new catheter bag is used that make sure it is dated and signed when changed ". With the individual's consent we looked the leg bags, they had no date of changing written on it. We checked the care records and could not find this information, we asked a carer who told us that, "They are done weekly." This information should be recorded to ensure responsive care and avoid infections.

The systems to manage the risks associated with wounds did not work effectively. Waterlow assessments were in place to assess people's risks of developing pressure ulcers and wounds. However actions were not

taken consistently to mitigate identified risks. For example we observed that two people were using pressure relieving equipment which was at the incorrect setting. One person mattress was set at 46-80kg, but staff had recorded that it was set at 31-45kg. However the person's weight was only 30kg which meant the pressure relieving effect was not working effectively and could be uncomfortable. Another individual pressure relieving cushion was set below the person's weight and did not give effective pressure relief.

Some individuals had been assessed as requiring, "a two hourly repositioning regime ". The time sections of the form gave times in 2 hourly sections, i.e. 06:00-08:00, 08:00-10:00, 10:00-12:00, 12:00-14:00. Carers did not record the actual time that care was given, so it was difficult to monitor whether people were being repositioned as required.

We found that two people had developed grade three wounds. Concerns were expressed to us that one of the wounds had recently deteriorated after being found without a dressing.

The shortfalls in the management of risks were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's medicines were not always managed safely. Handwritten additions or changes to the Medication Administration Record (MAR) charts had not always been signed and checked by a second member of staff and in one case the actual medicine name for an eye drop preparation was missing from the handwritten entry on the MAR chart. In another case the directions from the GP for the administration of an antidepressant had not been followed correctly and the person had received an incorrect amount of medicine. We asked the senior member of staff to seek advice from the GP.

Medicines that require additional controls because of their potential for abuse (Controlled drugs) are required to be stored safely and securely. The door to the Controlled drugs (CD) cabinet was missing. Staff told us that the key had broken in the lock which forced the staff to break into the cabinet to access the medicines. The door had not been repaired by the time we inspected and we did not see an incident report completed for the broken CD cabinet. The storage of Controlled Drugs were not in line with The Misuse of Drugs (Safe Custody) Regulations 1973. We found one bottle of morphine sulphate which was not stored securely within any cupboard. A bottle of 300ml had been dispensed for someone requiring occasional pain relief. This person had received three doses of 5ml according to records. However the bottle contained approximately 50ml liquid. The staff could not account for the missing amount of morphine. This had not been reported as an incident and we referred this matter to the safeguarding authority for investigation.

Medicines were stored in three trolleys which when not in use were stored safely in two locked rooms. One of these rooms had crumbling plasterwork and wasn't in a suitable condition to maintain cleanliness. The refrigerator within the room was not locked. This was not in line with the provider's medicine policy which specified a separate refrigerator should be available to be used and should always be kept locked. The temperature of the rooms were being monitored and were mostly within the recommended range, although the temperature of the second room had reached between 31-340C on four separate occasions. Medicines should be kept below 250C. The refrigerators were also being monitored but the thermometer did not measure the minimum or the maximum temperature and on our day of inspection it was reading 15oC, and the ice box was dripping water onto the boxes of creams below. Medicines requiring refrigeration should be maintained in the temperature range of 2 – 80C. During our inspection we saw some thickener stored on top of a bookcase in a corridor and a box of laxatives on the floor of the office. These areas were accessible to people using the service. In 2015 a patient safety alert from NHS England had been released regarding the risk of accidental ingestion of fluid/food thickeners which had resulted in death from asphyxiation. Therefore care providers should consider how to keep people safe from this risk, including the safe storage

of thickening agents.

Some protocols for the administration of 'as required' medicines were not available. These protocols provide guidance as to when it is appropriate to administer medicines that are not required regularly such as laxatives or eye drops. If there was a choice of how much medicine to give, such as a variable dose of laxative, the records didn't always clearly show what had been administered. Information on allergies was not always clearly recorded which could lead to an error being made.

Medicines that were applied as patches were not recorded appropriately. In one case an analgesic patch that needs to be changed weekly had not been recorded as being changed. In another case the transdermal record had not been completed and it wasn't always clear whether staff had rotated the site of patch application in line with the manufacturer's instructions.

There were no records for medicines being applied topically such as creams and ointments. Staff could not tell us whether topical preparations had been applied in line with prescribing instructions. Some creams and ointments were found in people's bedrooms and were not always prescribed for that person. Creams were not dated on opening and there were no instructions on where the creams should be applied. One person had a tube of over the counter medicine in their room, Voltarol gel which contains Diclofenac and is used to relieve arthritic pain by topical application. It should not be used for longer than 14 days and should not be applied to more than 2 body joints without a Doctors instruction. We could not see that the risks associated with using this had been considered. The manager told us that they were developing new documentation for staff to use for the administration of topical medicines but we were concerned that no interim arrangements had been put into place. We advised the deputy manager to instruct staff to sign the MAR chart until new guidance and forms become available.

We looked at the administration of medicines to a person who lacked the capacity to consent to medicine administration. In this instance, the medicines were being provided in a liquid form. Covert administration involves hiding medicines in food or drink and there must be a best interest's decision which includes the relevant health professionals and the person's family members. In this case it would have not been clear medicines were being administered as some were made up into a drink. We did not find any evidence of a best interest's decision. This particular person had a thickener added to liquids to make sure they were of a safe consistency to drink; there was no evidence that the liquid medicines were being thickened appropriately. In their care plan it was recorded that this person should have morphine sulphate when required for pain during personal care and turns but none was prescribed.

Medicine incidents were being reported, the last one being reported in January 2017. There was no evidence of manger's review or actions taken following the incidents. There was a programme of audit in place, but no evidence of actions taken when issues were highlighted.

The shortfalls in the administration of medicines were a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at how the service was staffed and were told there was a senior and five care staff on duty during the day and three at night. The manager told us that that they used a dependency tool to calculate the levels of staff that they needed to meet people's needs. The service regularly used agency staff as they had a number of staff vacancies in care and in the kitchen. People and their relatives expressed concern about the high turnover of staff and told us that some of the agency staff did not know their needs. Others told us that staff were not always available when they needed them. One person told us that, "There is not enough of the right staff." Another person told us, "Some good ones, (staff) but you sometimes have to wait."

Our observations were that staff were not effectively deployed and there was a lack of management oversight. This impacted on the quality of care that people received. New staff who had only worked one previous shift were supporting very vulnerable people with little direction. For example we observed a new member of staff supporting an individual who been identified as being at high risk of choking. The new staff were supposed to be working on a super mummery basis but this was not always evident. Lunchtime was chaotic and staff were very rushed. One individual was observed asking for help to go to the toilet but had to wait until staff were available. People did not receive the support they needed with eating which meant that some people's meal was left to go cold, others left the dining room without finishing their meal.

At our last inspection we found that the recruitment processes were not sufficiently robust and it was recommended that further improvements be made. At this inspection we checked the recruitment records of three recent staff appointments. We found that the systems in place had not sufficiently improved. Two of the three people we looked at did not have a full employment history on file. This meant that we were unable to check whether references had been obtained from the last employer and we could not see that this was checked at interview. Disclosure and Barring Checks had been obtained to check that they were not barred from working with adults in social care.

The shortfalls in staffing were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by the arrangements that were in place for the prevention and control of infection as staff did not have a good understanding of the procedures. We observed care staff undertaking care duties such as checking individual continence pads and repositioning them without the use of gloves and aprons. They then moved on to assist another individual without washing their hands. Staff were not always changing gloves between tasks. Staff should be washing their hands after each episode of care and when removing disposable gloves. Bacterial contamination on gloves will be spread onto door handles and any objects touched if not removed after giving care involving bodily fluids. We observed a member of staff emptying a catheter bag into a urinal, which was then placed on a shelf in the toilet. The urinal was not washed out or rinsed. This is poor practice, the urinal will have some urine remaining in it and over a period of time it will create an odour and have bacterial growth that could be transferred to the catheter drainage bag. We observed clinical bins containing bags of soiled items did not have lids and had an offensive odour.

The shortfalls in the management of infection control were a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff had variable understanding of what was abuse although the majority of staff were able to tell us that they would do if they had any concerns about an individual's welfare. One member of staff told us, "If I have concerns, and these are not dealt with by the manager I do have a number to ring to whistle blow. " The manager maintained a folder of safeguarding investigations that had taken place as well as information on the outcome.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection in February 2017 we found shortfalls in the induction process and recommended that the provider review the current induction programme for new staff to ensure it was more robust and linked in with the care certificate for new staff. At this inspection the manager told us that some changes had been made but we did not see any impact or benefits to people using the service. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. The care certificate was not being implemented and we observed newly appointed staff working with little effective leadership under very little supervision and direction. The manager told us that there was a new induction checklist and we saw that this was in place for one of the three new members of staff. However the majority of areas had been signed off as complete on one shift. We spoke with the new staff and found that they did not always have opportunities to shadow more experienced staff. For example we found that one of the newly appointed staff shadowed another member of staff on their induction as part of their induction. This is not satisfactory and newly appointed staff should be observing experienced staff to learn good practice.

The manager told us that staff were undertaking additional qualifications such as Qualification and Credit Framework which is a nationally recognised qualification for people working the care sector. There was a training matrix in place which showed what training staff had completed and we saw that staff had completed training in areas such as dementia safeguarding and fire procedures. Staff confirmed that they had opportunities for training although a lot of this was eLearning training. We had concerns about the effectiveness of some of the training as there were gaps in staff knowledge and staff were not following best practice in key areas such as moving and handling, infection control and the delivery of personal care. We observed two staff assisting an individual to move by pushing up on their shoulders rather than using a handling belt. Moving someone incorrectly can damage fragile skin and cause shoulder and neck injuries. We also observed staff not using protecting equipment and using undiluted foam bath for skin cleansing. This should not be applied directly to the skin as it causes the skin to dry out.

Staff skills varied significantly. We observed that one member of staff communicated well with people with dementia and de-escalated a number of situations where an individual was becoming distressed. Other staff lacked skill and knowledge around people with dementia, for example one person was becoming distressed and a member of staff walked past them and pointed at them and said to us, "All I can do is apologise; now she is going to create a fuss."

We could not see that there were checks on staffs competency and understanding of moving and handling or infection control. At the last inspection we had identified that there were gaps in training for example in support to people with diabetes and recommended that this be actioned. This had not been undertaken and some of the staff we spoke with did not know what to look out for if people's blood sugars changed and they were to have a hyperglycaemia or hypoglycaemia episode.

CQC is required by law to monitor the operation of the Deprivation of liberty (DoLS) and The Mental Capacity Act (MCA) which provide legal safeguarding for people who may be unable to make decisions about their

care. The records and care plans in place showed that the principles of the MCA code of practice had not always been followed, for example in the use of covert medicines. We could not see any reference to best interest decisions in people's records or care plans. The staff we spoke with were not aware of these being in place and they had a variable understanding of their responsibilities, one member of staff told us that, "I can't think of anyone here that lacks capacity, or who needs best interest decisions." One of the relatives we spoke with had power of attorney for their relative and told us that that they were not consulted or always kept informed about their relative's needs. The manager subsequently told us that there was a folder with best interest decisions and we have recommended that this information is included within the care planning process and subject to review.

We were told that some applications had been under the deprivation of liberty (DoLS) with regard to people leaving the premises and we saw reminders in place for further applications to be considered when they were due to expire.

Feedback regarding meals was variable. Some people told us that they enjoyed the meals but others were less positive. One person told us, "The food is marvellous the chef can't do enough for you." Another person told us, "Sometimes I can't eat. I don't like the look of it." They told us that that normally have two choices but sometimes only "one choice or what was available."

We observed lunch and saw that the portion size was adequate. Staff asked people verbally what they wanted although did not show people plated up options to help promote their choice. Some people would not be able to express a meaningful choice without visual support. We asked a member of staff what the pureed meal was and they told us it was meat but they did not know the type.

We heard some staff trying to encourage people to eat and some people were brought alternatives when they refused what was offered. However there was not enough of staff available in the dining room to support people and some people sat for nearly an hour waiting for their food to be served. Some people needed their food cut up or prompting to eat as they fell asleep. Meals were left to get cold; other individuals got up and walked away. We saw a number of plates were returned to the kitchen with significant amounts of food waste still on them.

We were told that people who were identified as being at risk of malnourishment were being given fortified food and weighed more regularly. We saw that referrals had been made to the dietician and advice had been provided, however this was not always followed by staff. For example we saw that the dietitian had recommended that some people have smoothies and additional snacks between meals but this was not borne out by our observations. When we checked individual's daily food and fluid records we could not see that they had been offered. We spoke to the chef about this and they told us snacks would be provided at request but it was not clear how people would be able to request additional food as some were highly dependent on staff.

People had access to health care support. We saw evidence of referrals to a range of health professionals such as the speech and language service, GPs and chiropodists. One person told us, "The chiropodist comes in once a fortnight- one of the girls do our fingernails."We saw that the GP and district nurse visited regularly to support the staff team.

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection we found that caring, required improvement. At this inspection we had variable feedback. Some of the comments included, "The girls are very good, they get things for you." And "Staff are kind, but there are a couple of staff who have a bit of an attitude."

At this inspection we observed several occasions when people's privacy and dignity was not maintained. We observed people wearing soiled clothing in the communal areas. Some were wet from spillages but one individual was observed just prior to lunchtime slouched in a wheelchair with the remains of their breakfast down the front of their top. Their mouth was sticky with food remnants. As we were walking around the building we heard crying from outside an individual's room and when we entered found the individual to be very uncomfortable. They had recently been repositioned and had been left, with their nightdress buttons undone. The nightdress was pulled tight so that their right arm was pulled under their body causing them discomfort. We located the two members of staff who had repositioned the individual and asked them to release the nightdress so that the individual could move their arm and fasten the buttons. We observed people being moved using the hoist. A number of individuals were wearing dresses and skirts and while some staff obtained a blanket to protect the individuals dignity this was not undertaken consistently and people's undergarments were visible to people sitting nearby. We noted a pair of false teeth on the side of the window which did not belong to the person sat next to them.

We were not assured that people always received care which took account of their wishes and what was important to them. We observed a number of people spent a lot of the morning asleep in the communal areas and we were not clear that peoples preferences regarding the times of getting up where being met as they were not documented in their care plans. One person told us, "Some people are got up very early then sleep all day." We asked staff about this and they told us that the night staff get about half the people up some days. We received a complaint about this prior to the inspection. Some relatives expressed concerns about their relative's general appearance. They reported that clothes went missing and they found their relative in other people's clothes. They told us their family member was always well dressed and well-presented when younger but said this was not maintained in the care home. Another relative told us that their family member had loved their garden when younger and this was always admired but they now spent their day in the same chair and did not go outside.

We spoke with staff about the support that they provided to people and it was clear that they meant well. However they described a service that focused on completion of tasks and following routines rather than peoples individual's needs or preferences. They had little understanding of the impact of this approach and told us that drinks were at fixed times and referred to people as singles or doubles rather than always by name. This focus on the completion of tasks, corresponded with our observations and we observed staff lining people up in the wheelchairs and pulling people backwards in specialist chairs as they moved them.

The shortfalls we found are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Whilst we saw examples of poor practice we also some lovely interactions where staff were kind and patient. We saw one person being assisted to transfer from their armchair to a wheelchair. The member of staff provided lots of reassurance and a running commentary saying, "Hold on nice and tight." And, "Going up and going down." They smiled at the person who looked relaxed and they laughed. We overheard a conversation about nails needing trimming and it was undertaken in a warm and friendly way. The person said, "No they don't" need doing but the member of staff responded with laugher "oh yes they do, shall I come back later and do them?" The individual agreed, with a chuckle.

Requires Improvement

# Is the service responsive?

## Our findings

At the last two inspections we found that care plans did not sufficiently guide staff which placed people at risk of inappropriate care and there was a repeat breach of the regulations. At this inspection we continued to find shortfalls in care planning and how staff responded to people's individual needs. The feedback we received from people and their relatives varied, one person told us, "Staff are reasonable, they do fairly well, I don't really have any problems." Another said, "Things are okay, it varies day to day with lots of agency staff, who work hard but don't really know people's needs." One of the relatives we spoke with expressed concern that some staff did not know their relatives needs and told us that they had given their relative the wrong diet increasing their risk of aspiration.

We looked at a sample of care plans and we saw that they were consistent in format but they lacked a person centred approach. They used terms such as give care as necessary or make comfortable. They did not address people's specific needs or preferences or give staff guidance, for example we saw that one person had been identified by their GP as requiring end of life care but this information was not contained within their care plan. Another care plan referred to the person being independent with eating and drinking when this was clearly not the case.

None of the care plans we looked at identified the size of individual's continence pads. None of the packs of continence pads were individually labelled and they were stored in a communal area. We asked staff about this and they told us that most people had a blue one. This is not personalised care, the continence products are assessed for each individual person. Using a pad that is too large may cause skin around the groin area to become red or sore, if the pad does not fit closely to the body it will allow urine and faeces to leak onto other clothing and be undignified for the person. If a too small pad is used it may not contain all the urine passed and leakage may occur causing skin breakdown, soreness and pain and discomfort.

People's needs were not consistently monitored and information was not handed over or always acted on. For example we found an individual who was distressed and staff told us that told us that she always cries when we move her. We asked about pain relief and were told, "We've reported it lots of times." We could not see a record of this being actioned and there were no pain charts in place to measure and assess pain. The management of pain relief had been raised at a previous inspection as needing addressing. We spoke to the manager about our concerns and they told us that they put in pain charts if needed.

Care was not always recorded as provided, for example we observed lunch and saw that some people did not eat well. We subsequently checked the records completed by staff and saw that they were not always making accurate recordings as they were not being completed contemporaneously. For example they had recorded for one of the people that we looked at that they had eaten fish and chips but we observed that they had eaten very little. Another person's records indicated that they had eaten but we observed that they had refused. Oversight was not sufficient and we saw that some people's records indicated that they had gone a number of days eating very little. This information was always handed over and there were not records to evidence that it had been acted upon or analysed as to the reasons.

The record keeping regarding bowel movements was poor and we could not see how those supporting people had oversight of this. We noted from a review of people's daily records that some people had gaps of up to nine days where there had been no record of bowel movement. We had concerns as a lack of monitoring of bowel movements can mean that the indicators of constipation are missed. Constipation can cause nausea, vomiting, dehydration and increased confusion especially in those older people with Dementia.

Some relatives told us that the service communicated with them well but others were less positive and expressed concerns as to what might happen if they did not visit, as they did not think that staff were sufficiently observant and proactive.

There was a repeat breach of Regulation 9. Person centred care. Health and Social Care Act (Regulated Activities) Regulation 2014

We looked at the social life of the service and saw that there was an activities coordinator employed. People were observed participating in activities, some chose not to and others needed encouragement to join in. Activities were provided by the activities coordinator who was able to successfully engage people. However we did not observe any care staff supporting them which meant they were not able to engage more people and got distracted and involved in delivering care.

We could not see that complaints were used in a positive way to improve the quality of care. Relatives gave us variable feedback on how the service responded to their concerns. Prior to the inspection one person contacted us and told us that their complaints were not taken seriously and were told if they did not like the care that was being provided that they could move their relative elsewhere. Another relative told us that the concerns that they raised had not been addressed. We found that there was a complaints procedure in place however it had not been updated for some time and directed people to a CQC office which was no longer in use. There was no information provided about the role of the ombudsman. We looked at the records of complaints and saw that none had been recorded as received since 2015. Residents meetings asked people for feedback and if they had any complaints and we saw that none were recorded.

Inadequate

# Is the service well-led?

## Our findings

At the comprehensive inspection in September 2016, Well led was rated as Inadequate as we identified concerns relating to the oversight and quality monitoring of the service. This meant that the risks to people's health, welfare and safety had not been effectively identified and steps taken to mitigate these risks. At the inspection in February 2017 we found some improvements as the service had benefited from support from the local authority. At this inspection we found that there was a lack of effective oversight of the service. Sufficient controls were not in place to mitigate the risks to people's health, welfare and safety including the management of people's medicines, those at risk of falls and acquiring pressure ulcers. The local authority had gradually reduced their levels of management support, and despite the lower numbers of people living in the service, the homes management had failed to sustain some of the improvements that they had made.

There was no registered manager in post as required by law. The provider had employed a manager who was a qualified nurse and who had been in post since August 2016. They told us they had applied to be registered with CQC but we have no record of an application being received. The manager had been working with an external management consultant to drive improvement at the service but we were told that they were not longer supporting the service.

There had been some management changes since the last inspection with the appointment of a new acting deputy manager and acting care coordinator. The manager was not present on the first day of the inspection and we were assisted by the acting deputy manager who was helpful but unable to provide us with all the information we needed. The new deputy manager had not yet had an induction and the manager and provider had not been on site for a number of days. There were on call arrangements but these were not effective as the manager was only available by telephone and would not have been able to attend the service in an emergency.

People using the service spoke positively about the manager, one person told us, "The Manager, is okay, I can discuss any problems I may have with her." Staff were also positive and told us that they were approachable and helpful, The comments included "She is really strong, I wouldn't like to cross her. They are there for the staff and very supportive. "And "It's a pleasure to come to work now. " And, "Things continue to improve, good care practices, good interactions." When asked about the practical changes that had been made, one member of staff told us that the paramedics now received more up to date information which meant that transfers of care worked better.

Staff told us that morale was satisfactory but expressed some concern about the turnover of staff and one member of staff told us, "There has been good team work, but we are losing a lot of staff at present, two have left already, others leaving."

At the last inspection the manager told us that they had made changes at the service with the aim of driving improvement. These changes had included giving staff responsibility for specific areas such as nutrition and we saw that this was continuing. They told us that they were trying to prioritise the areas that needed action.

We were not clear about how the priorities were set as some of the changes that had been made had not been sustained. For example in areas such as medicines, infection control and oversight of meals. We also saw that other areas which we had identified at the last inspection had not moved on significantly for example issues with staff recruitment, induction, handover of information and care planning.

The culture of the service was task focused and the practices that we observed during the inspection were not always good. Some staff were very caring but others were focused on completion of tasks. There was a lack of direction on shift and staff did not always display the right values. They were in need of leadership and further guidance to improve the quality of care provided.

The quality assurance system was not effective and did not underpin improvements. During the inspection we looked at how the manager and provider ensured the quality and safety of the service and we were shown a number of folders which contained checks that were undertaken on care practice and the environment.

There were checklists in place to evidence that equipment was checked but these were not audits with findings and actions setting out improvements needed. For example we saw that maintenance staff signed to confirm that checks were undertaken on the fire safety equipment to make sure that it was working effectively and monthly checks on water temperatures were undertaken to make sure that the temperature of the water was not excessive. However the oversight was not robust as the window restrictors had been ticked as correct when they were clearly not in place. There was some evidence of portable appliance testing (PAT) testing being undertaken but this was not up to date. PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.

We looked at the audits that had been completed on infection control and were shown a weekly environmental audit tool which looked at cleanliness. These were not up to date and focused on cleanliness of the building; They had not identified some of the issues that we had found and we could not see that practice or equipment such as hoists were included as theywere not clean. This meant that people were not protected from the risks of cross infection

The manager relied heavily on the computer system for auditing and told us that they could pull off reports on areas such as falls. They provided us with a list of people who had fallen but there was no analysis as to the reason and any contributing factors such as the time of day falls were occurring and the location. Similarly we saw that there had been a number of skin tears but there was no evidence of analysis as to the reasons and actions to prevent reoccurrence. The manager told us that some of these had been caused by damaged wheelchair which had been replaced and agreed to investigate a number of others which we identified.

The shortfalls in the management and oversight arrangements were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Policies and procedures were available to guide staff in their role; however we found that they were largely dated 2007, a number of these required updating to ensure they reflected current legislation and best practice. There was a service user guide which sets out what the service provides and what people should expect. This had not been updated since 2014 and some of the information did not reflect our experience of what was provided. For example it said a pay phone was available for people to use. This was in the main foyer and did not work and would not be accessible to people as there was a locked door leading to the foyer. It referred to six monthly inspections from CQC which has not been the practice for many years. It spoke about people being able to have private phone lines at an additional cost but when we asked the

administrator they did not think anyone did. It said fire exits were sign posted by a running man, this was not the case. It also said there were no restrictions when doors were locked.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations 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 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<br><br>Records were not always accurate and did not provide sufficient guidance to staff to ensure people's needs were met. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not always treated with dignity and respect |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People who use services and others were not protected against risks as the controls in place were not effective<br><br>Medication was not safely managed<br><br>Staff were not following safe infection control procedures |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The quality assurance system was not effective and did not drive improvement |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were not effectively deployed to meet people's needs