Cygnet Health Care Limited

Tabley House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an inspection of Tabley House on 22 and 26 March 2018. The inspection was unannounced. Tabley House is registered to provide accommodation for up to 59 adults with nursing and personal care needs. At the time of the inspection 49 people lived at the home.

Tabley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the first day of our inspection, the registered manager was on annual leave, so the deputy manager assisted us with the inspection. On day two of the inspection, the registered manager had returned to work and participated fully in the inspection.

We looked at the care records belonging to six people. We found their needs and risks were not always properly assessed or managed. There was not always adequate information on how to meet people's needs and to provide their care in the way they preferred. Some of the risk management strategies in place were inadequate and did not provide staff with sufficient guidance on how to manage people's risks and keep them safe.

People's capacity was not assessed in accordance with Mental Capacity Act 2005. There was no evidence of any best interest meetings and some of the care practices at the home were restrictive and institutionalised. For example, some people had bed rails in place, their bed heightened so they could not get in them and one person was placed in a recliner chair during the day to prevent them from getting up unsupervised. These types of decision under the MCA are considered restrictive practices, as they restrict people's liberty or freedom of movement. Despite this the MCA had not been followed to ensure these practices were in the person's best interests and legally consented to.

Medicines were not safely managed. Stock levels of people's boxed medications were incorrect and medication could not be accounted for. There was no robust system in place to record the administration of people's thickening medication or to check the correct amount of thickener had been added to people's drink to prevent a choking or aspiration incident. We saw that one person's thickener was used for other people in the home who had not been prescribed it. Staff lacked sufficient guidance on the application of prescribed creams and other topical medications.

During our visit, the majority of feedback from the people and relatives we spoke with about the food on

offer was positive. When we checked some people's care records however we saw that their nutritional needs were not always met in a safe way. This was because some people's special dietary requirements were not always catered for and some people received an unsuitable or insufficient diet for their needs. Catering staff lacked sufficient information about people's special dietary requirements and lacked an understanding of the importance to cater for these needs. Referrals to the dietician in support of people's needs had not always been made to ensure people were protected from the risk of malnutrition.

Staff were not always recruited in a robust way and staffing levels were insufficient to meet people's needs. As a result people experienced falls and incidents due to a lack of adequate supervision. This was because some people who required close monitoring and supervision often fell when staff were not present to supervise them appropriately. In addition records showed that people did not always receive the care they needed to meet their needs in accordance with their care plans. Staff training for permanent staff was satisfactory but agency staff lacked evidence of a suitable induction into their job role. The manager failed to ensure agency staff had sufficient information about people's needs and the service in order to provide safe and effective care. Some staff lacked sufficient knowledge of people's moving and handling needs to ensure people were supported correctly and in a safe way.

The manager and staff at the home had not always recorded accident and incidents adequately or taken appropriate action to safeguard people against future risks. Incidents of a safeguarding nature had not always been identified, responded to or referred appropriately to the local authority and CQC. There was little evidence some of these incidents had been properly documented or investigated by the manager to protect people from risk.

Some people's ability to be independent was hindered by the environment. The environment was not dementia friendly. There was no adequate signage within the home to help people find their way around and no contrasting colour schemes to help people differentiate between different areas of the home. There were also some repair and maintenance issues within the home needed to be addressed. Safety checks on the home's equipment had been undertaken appropriately.

There was a complaints policy in place. Two people told us that their complaints had been satisfactorily dealt with. During the inspection one person's relatives told us they had concerns about the care their loved one received. We spoke about these concerns directly with the manager and deputy manager. They later withdrew this complaint. Most of the people we spoke with felt the service was well-led. We found evidence to the contrary.

There were no effective systems or processes in place to ensure that the service provided was safe, effective, caring, responsive or well led. Audits were undertaken but they were ineffective in identifying the issues found during the inspection. The provider did not play an active role in the service and had not undertaken any effective checks on the service to ensure it was safe and satisfactory. This meant the service was not well led.

After our visit, we asked the manager and provider for an urgent action plan on how they were going to ensure immediate and significant improvements were made. An improvement action plan was submitted and is in progress. This assured us that some of the risks and concerns we had identified during our inspection were being addressed immediately. Referrals were also made to the local safeguarding authority and other health and social care professionals to protect people from risk and to ensure they received the support they needed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special

measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's individual risks in the planning and delivery of care were not always properly managed and people's medicines could not always be accounted for.

Incidents of a safeguarding nature were not always dealt with appropriately.

Staff were not always recruited safely. Staffing levels were insufficient to meet people needs.

Is the service effective?

Inadequate

The service was not effective.

People's capacity was not assessed in accordance with the Mental Capacity Act 2005 and restrictive practices were sometimes used without appropriate authorisation.

Permanent staff received adequate supervision and training but agency staff did not.

Systems in place to monitor and manage people's nutrition and hydration risks were not robust enough to ensure people's needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and patient when people needed support and people were treated with dignity and respect. People we spoke with confirmed this.

People's ability to be independence was not always enabled.

People's personal information was stored safely to protect their confidentiality.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans lacked information of people's needs and preferences to enable person centred care to be delivered. Some staff lacked knowledge about their needs in order to be responsive.

Varied group activities were provided for people who lived at the home but there was little one to one activities for people who lived with dementia.

The complaint system in place and people told us their complaints had been dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

There were no effective systems or processes in the home to ensure that the service was safe, effective, caring, responsive or well led.

The provider did not have sufficient oversight of the service and did not effectively check that the quality and safety of the service was satisfactory.

Tabley House

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 22 and 26 March 2018. The inspection was unannounced. The inspection was carried out by two adult social care inspectors, a specialist nurse advisor and two experts by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also contacted the Local Authority for their feedback on the service. The Local Authority had no concerns about the service.

We spoke with 14 people who lived at the home and nine relatives. We spoke with the registered manager, the deputy manager, the clinical lead, three nurses, a care assistant and catering staff. We also spoke with three visiting healthcare professionals consisting of a GP, a dietician and a nurse.

We looked at six people's care records, five staff files, staff training and supervision information, medication administration records and other records relating to the management of the service.

We observed people and staff throughout the inspection and saw how people were cared for. We did a tour of the home which included communal areas and a random selection of people's individual bedrooms.

Inadequate

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe at the home. We found however that their care was not always provided in a safe or appropriate way.

We looked at six people's care records. We found that some but not all of people's risks in the delivery of care were assessed. People's risk management plans were sometimes confusing and the guidance give to staff was not always clear. Where guidance had been given, this guidance was not always followed by staff to ensure people's safety.

For example, one person lived with a specific medical condition that meant they required specialised equipment to maintain their physical health. We found the medical condition had not been properly described or risks assessed. There was also no risk assessment and management plan in place for the use and maintenance of the person's specialist equipment. The deputy manager told us that some of the staff had not received training in how to check and maintain the person's equipment. This meant there was a risk that staff lacked sufficient knowledge of how to ensure this person's needs were met.

Two people whose care files we looked at had swallowing difficulties. This placed them at risk of choking or aspiration pneumonia. Aspiration pneumonia occurs when a foreign body, such as a small piece of food goes 'down the wrong way' causing a chest infection to develop. We found that neither of these risks were adequately assessed and managed. Staff had no guidance on the signs and symptoms to spot in the event of a choking or aspiration incident or what to do should one occur.

One person's ability to swallow had been assessed by the Speech and Language Therapy team. Staff were advised to ensure the person received a soft diet to mitigate the risk of them choking. The person's food and drink charts showed they sometimes received a diet that contradicted this advice. We asked the manager about this. They told us it was the person's choice. We found evidence in the person's care file however that concerns had been raised about the person's capacity to understand the risk associated with their food choices. The manager had not ensured the person's capacity had been assessed in relation to these choices and there was no evidence that the risks of them consuming an unsafe diet had been assessed and strategies put in place to minimise the risk of harm. There was also no evidence that further advice from the SALT team had been sought. We saw that this person had experienced at least one choking episode as a result of these choices.

A significant number of people who lived at the home did not have access to a call bell in their bedroom to press for help. People's records stated this was because they were unable to use them but there were no risk assessments in place in any of care records we looked at to show how this had been assessed. There were also no adequate alternative risk management strategies in place to mitigate the risk of people not being able to call for help when they needed it. We asked the manager and a nurse told us that staff checked on people's welfare every two hours when they were in their bedroom. We found this practice to be unsafe. This was because the frequency of these checks was inadequate. People who did not have a call bell in place where amongst some of the most vulnerable people who lived at the home, the layout of the

home was complex and some people's bedroom where located behind two or three fire doors or on the upper floors. This meant it was unlikely staff would hear people shouting for help if they fell or needed help in between the two hourly checks. We asked the manager to address this without delay. After our inspection we were told that these checks had been increased to every half an hour. We were also advised that an upgraded call bell system was to be installed.

One person's accident and incident records showed that they had fallen over 30 times since July 2017. When we looked at their mobility risk assessment, no additional risk management measures had been put in place to reduce the risk of the person's repeated falls. There was no evidence that the person's mobility needs had been assessed by an occupational therapist or that a referral to the falls prevention team had been made to identify if any additional safety measures should be put in place.

The person's accident and incident records showed that the majority of their falls occurred when they were not being supervised appropriately by staff in accordance with their risk management plan. This meant the falls may have been avoided had appropriate supervision been given. Some of the person's falls had also occurred when staff had failed to provide safe and appropriate care. For example, two falls were as a result of staff leaving the person in a wheelchair without their lap belt on and the person had fallen out. We asked the manager if these incidents had been reported to the local authority safeguarding team for further investigation or CQC. They told us they had not.

Another person's accident and incident records were equally concerning. We saw that this person had fallen and been found on the floor of their bedroom and bathroom 12 times in a 12 month period. There was little evidence that appropriate action had been taken to prevent further harm. We asked the manager if this person had been reported to the falls prevention team, their GP or local authority safeguarding team for specialist advice and support. They told us no referrals had been made.

We saw that whilst people's accident and incident forms had been completed by staff members as and when they occurred, there was no evidence that they had been reviewed and investigated by the manager. We asked the manager for evidence that people's falls were investigated in order for staff to learn from and prevent similar accidents occurring in the future. No evidence of any investigation or learning was available.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's risks were not always appropriately assessed and safely managed.

People's daily records showed that incidents of a safeguarding nature had occurred. For instance, one person had voiced concerns to the manager about the skills and abilities of staff to support their moving and handling needs. They alleged this caused them pain and discomfort. We asked the manager if these concerns were investigated or referred to the local authority. The manager told us they had talked to the person about their concerns but acknowledged there was no incident or investigation records to evidence this. They told us that they had not referred the person's concerns to the local authority safeguarding team or CQC.

One person told us that some of their personal belongings had gone missing from their bedroom. They said they had reported this to staff. We asked the manager about this. The manager told us they were aware of the person's concerns but acknowledged no record of the person's concerns had been made. There was no evidence that they had been properly investigated and the manager acknowledged they had not reported the person's concerns to the local authority safeguarding team or CQC.

During our visit, a relative told us that their loved one had been placed at serious risk by a fault with their equipment. We saw that there were some details of the incident documented in the person's daily notes but there was no evidence that the relative's concerns about the equipment had been investigated or referred to the local authority safeguarding team for investigation. The manager told us the equipment was not at fault but was unable to produce any evidence to confirm this or any evidence that they had investigated the incident.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was a lack of robust systems to protect people from the risk of potential abuse.

We found people's medicines were not always managed safely. The provider used a monitored dosage system for some of the medications people needed. This type of system provides the person's medication in a pre-prepared blister pack. We found that this medication was administered correctly.

Some people had additional medication that was dispensed in individual boxes and bottles. Three people's additional medication was checked equating to ten different medicines. A stock check on these medications was carried out and the majority were incorrect. Six out of the ten medications checked did not contain the correct amount of medication according to the person's records. For example, one person's medication administration chart indicated that the person should have had 48 tablets of one medication left in the box. When we counted the amount of tablets remaining the total was 76 tablets. This meant there was a discrepancy of 28 tablets. These tablets at the time of our visit were unaccounted for. We were also unable to verify the stock of one medication, as there was no carried forward amount of medication from the previous medication cycle recorded, to enable us to do this.

Some people required a thickening agent to be added to their drink to ensure they were able to swallow safely when drinking. Thickening agents are used to thicken the consistency of fluids to reduce the risk of a person choking. During our visit we observed one person's prescribed thickening agent being used by staff to thicken another person's drinks. Each person is different and needs to have a different amount of thickener in their drinks in order to swallow safely. The amount of thickener agent to be added is prescribed by a medical professional. When we checked this person's care records we found that they had not been prescribed this medication. This meant it was added to the person's drink without any medical advice or authority to do so.

Care homes are required to keep records of all of the medications they receive, manage and administer. Despite this, there were no signed records to evidence that people's thickening medication had been administered. Nursing staff simply ticked the person's MAR chart to indicate this medication had been given. This was not in accordance with best practice guidelines. Nursing staff did not administer or observe the consumption of this medication prior to ticking people's medication records.

Various prescribed creams and gels were found to be stored in people's bedrooms un-securely. Two people's prescribed thickening agents were also accessible to others for unauthorised use in the communal dining room. Some people had 'as and when required' (PRN) medications such as painkillers or prescribed creams. We found that staff lacked adequate information on how and when to administer these medications in order to maintain people's comfort.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the management of medication was unsafe.

We looked at the staff rotas for March 2018. We saw that that there should be three nurses and ten care staff on duty 8am until. 2.45pm. Three nurses and eight care staff were then on duty from 2.45pm to 8pm and two nurses and five care staff from 8pm onwards. This amount of care staff did not seem unreasonable based on the number of people who lived at the home. When we looked at the information the provider had on people's needs and considered the layout of the home, it became clear that this level of staffing was insufficient. There were also times when the number of staff on duty did not correspond with the staffing levels identified as required by the provider.

For example, 48 people lived at the home, 15 (30%) people required two staff to assist them at all times. 13 people required the use of a hoist for transfers to and from bed or to and from a chair and 23 (47%) of people required the use of a wheelchair as they were unable to mobilise around the home independently. There were a significant number of people who lived with some form of dementia and ten people who lived with advanced dementia who required staff supervision at all times. This indicated that the majority of people who lived at the home were reliant on staff for most of their needs.

There were gaps and inconsistencies with the way people's care was provided. For example, records showed that people's falls were often unwitnessed by staff despite some people requiring close supervision. There was little evidence that people who needed repositioning were given this support and some people's daily records showed they went long periods of time without continence support. For example, one person's daily records showed that they were assisted to the toilet at 7:19 am. The next recorded assistance with toileting that this person received was at 10:51pm over twelve hours later. The gaps and inconsistencies in people's care indicated that there were not enough staff on duty to meet people's needs and ensure their safety at all times.

People's opinions about staffing levels were mixed. Their feedback included "I think there are enough staff. Yes they come quickly"; 'I think there are enough staff. Only occasionally I wait a bit longer' [for them to come] and Normally you don't have to wait". Whereas other people said "I think they are always short staffed. Eight to ten minutes to answer buzzer sometimes but it varies" and "Sometimes it's a bit longer than it should be; it can be longer than 15 minutes". A relative we spoke with also said "It depends. It could be as long as 10 or 15 minutes, if everyone is asking at the same time, that's ok".

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staffing levels were insufficient to meet people's needs at all times.

We looked at five staff files. We found that improvements to the way staff were recruited was required. The majority of the job applications we looked at were sparse in detail about the staff member's suitability. Two people had not provided full or complete details of their previous employment history and some of the previous employer references provided in support of a staff member's application had not been verified. This meant that the provider could not be certain that the references provided were from an appropriate and reliable source. One of the nurses whose staff file we looked at did not have an up to date PIN number registered with the nursing and midwifery council as it had expired in February 2018. Without a valid pin number, nursing staff cannot work as a nurse or a midwife in the UK. We drew this to the manager's attention who told us they would address this without delay.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff recruitment and induction processes were not robust.

We saw that the home's gas, electric, fire alarm and moving and handling equipment had been inspected and were safe to use. During our visit however, we found that parts of the home were malodorous and

required repair.

Three people's bedrooms smelled offensively from the outside. Some of the windows in people's bedrooms did not open which limited their ventilation. Four bedroom doors which were fire doors had a gap between the door frame and the bottom of the door which meant they would not offer sufficient fire protection in the event of a fire. Some of the home's fire doors were propped open with wedges or other items which meant they would not close automatically in the event of a fire. We spoke with the maintenance officer about the fire doors and they agreed to contact Cheshire Fire Authority for advice straightaway.

The clinical storage room in the basement area required cleaning and the floor required a deep clean as it was dirty. A passenger lift in the home contained a wet floor sign and other debris that had been inappropriately placed in there and left. As a result people who required the use of a wheelchair may have found it difficult to get in and out of the lift. It also posed a trip hazard to people who were mobile and able to access the lift independently

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that significant improvements were required.

We checked people's care files and found little evidence that people's capacity to make decisions was assessed in accordance with the Mental Capacity Act where their capacity was in question. People's capacity was assessed on admission. People's capacity assessments were in most cases generic with the specific decision the person's capacity was being assessed for, not always stated or clear. There was no evidence that subsequent capacity assessments or best interest decision making was undertaken when a decision requiring formal consent was made.

For example, some people had bed rails installed on their beds. Bed rails are used to prevent people accidentally falling, slipping, sliding or rolling out of bed but they require formal consent for use, as they are considered a form of mechanical restraint. We found that the decision to install bed rails on some people's beds was made without seeking legal consent in accordance with the MCA.

One person's care records advised staff to place the person in a recliner chair in the lounge during the day as the person attempted to get up independently. This suggested that the recliner chair was being used as a method of restraint in order to prevent the person from being able to get up out of the chair themselves. We checked the person's care records to see if the mental capacity act had been followed with regards to this. No evidence was found. The person's capacity had not been assessed with regards to this practice and there was no evidence that any best interest meetings had taken place to determine if this decision was in the person's best interest. There was also no evidence that any least restrictive options had been explored and no DoLS had been submitted to the Local Authority to seek legal consent for this restriction.

A number of people who lived at the home had advanced dementia and required close supervision. We saw that people who lived with advanced dementia were all brought into the lounge during the day and not able to return to their own bedrooms. When we visited people's bedrooms we found that some people's beds had been raised to the highest setting which meant it was difficult for people to get into bed. We asked the nurse on duty about this, they confirmed that these practice was used to prevent people being able to climb into bed of their own accord. This placed a restriction on the people's liberty and freedom of choice. It also indicated that the way some people's care was delivered was institutionalised.

Records showed that some decisions with regards to people's care were made by their relatives. The Mental Capacity Acts 2005 (MCA) indicates that next of kin have no legal right to make decisions or give consent on people's behalf if the person lacks capacity unless they have authority to do so under a Lasting Power of Attorney (LPA) or a Court Appointed Deputy.

Some of the care records we looked at stated that a relative had LPA to make health and welfare or finance decisions on the person's behalf but there was no evidence that this was the case. The manager had not checked that people's relatives had legal power of attorney rights before permitting them to make decisions on people's behalf.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain people's consent in accordance with the MCA.

We found that the premises was not a dementia friendly environment. Little consideration had been given to how the environment could support people who lived with dementia to remain as independent as possible for as long as possible.

For example, signage throughout the building was limited. Pictures on the walls around the home were very similar which would have added to people's confusion when they tried to find their way around. People's bedroom doors did not have any identifiable features to enable them to easily identify which bedroom belonged to them. The majority of bathrooms and bathroom fittings were white with no use of contrasting colours such as different coloured doors or walls or contrasting toilet seats to help people recognise and differentiate different objects and areas of the home in order to make sense of their surroundings. The layout of the home was complex with lots of corridors and doorways and the pastel décor of the home did not make it easy for people to distinguish between different parts of the home in order to find their way around.

Heavily patterned carpets were in use in some areas of the home for example in the lounge area. Research has shown that people who live with dementia may find this confusing as they can sometimes interpret patterns in the carpet as holes or steps. There was also a slope leading into one of the communal lounge with no adequate signage to warn people about the change in footing. This placed people at risk of a trip or fall.

We saw that people's nutritional risks were assessed but not always safely managed and some people's special dietary requirements were not catered for in a safe and effective way. This placed people's health and well-being at risk.

One person's recorded weight on the 15 March 2018 was 33.3kg with a BMI of 12.2. Their weight had been monitored over previous months and the person was considered by nursing staff to be significantly underweight. Despite this, no referral to a dietician in support of the person's nutritional needs had been made and there was little evidence that the person received a sufficient diet to prevent further weight loss. For example on the day of our visit, the person's tea time meal was a bowl of scrambled eggs. There were no carbohydrates provided for instance potatoes, bread or pasta or other form of protein such as lean meat or soya. The person's food and drink charts did not show the person received enough to eat and drink or that dietary supplements were provided to boost the person's calorie intake.

We saw that the person was identified as having a multiple food intolerances to certain food types. Yet their food and drink records showed they regularly received these foods. On the day of our visit, we observed that

the person was given one of the food types they were intolerant to at tea time. We asked the cook about this who acknowledged that they knew the person was allergic to certain foods but they gave the person what staff asked them for. We spoke with the manager who told us the person was intolerant rather than allergic to the food types provided. This contradicted the person's care plan. The manager described the type of reaction the person would sometimes experience when these food types were given. We noted that on the day of the inspection, the person had experienced a similar reaction to the one described by the manager earlier on in the day.

Another person lived with a diabetes. We saw that their blood sugars were monitored regularly by staff to ensure the person received the correct dose of medication to manage their diabetes. There was however no adequate information in the person's care file about the type of diabetic diet the person required. During the month of March 2018 we saw that this person's glucose reading was extremely high. Records showed that the person had been given fruit juice by staff and this had been recorded as the reason why the person's glucose reading was extremely high.

Sugar levels in fruit juice can cause a significant spike in blood sugar levels, increasing the risk of hyperglycaemia (too high blood sugar levels). The amount of fruit juice consumed by people who live with diabetes should be carefully monitored and accounted for in their daily intake of carbohydrates, otherwise it can place them at risk of health complications.

During our visit we spoke with a visiting dietician about people's dietary needs. They said "I have a few with diabetes. I noted a chap over consuming fruit juice". They told us that some aspects of people's dietary support and staff knowledge and awareness of diabetes needed to improve. The dietician we spoke with told us that they had offered the manager the opportunity for staff to attend free nutritional training on a number of occasions but this offer had never been taken up.

We visited the kitchen and saw that catering staff had insufficient information on people's food and drink preferences and special dietary requirements. This placed people at risk of receiving a diet that was unsafe or unsuitable for their needs. For instance, some people's care plans stated they needed a diet fortified with extra calories and nutrients but when we asked the cook about this, they told us no-one who lived at the home received a fortified diet. This meant there was a risk that people were not in receipt of the diet they needed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider has not done all that was reasonably practicable to mitigate people's nutritional risks and meet their needs.

Some people commented that at times the menu could get a bit repetitive but most people were happy with the quality of the food provided. Their comments included "Food is very nice. Sometimes we get a choice"; "Food's very nice. Better than at home. We get a choice. Breakfast when one's ready'; "Food is good, easily enough to eat and drink'" and "'Food is very good. Sometimes I like more but I put small portions as I don't want to get any fatter".

We saw agency staff sometimes worked in the home. We asked the manager for evidence that agency staff received an induction into their job role when they first started working in the home. No evidence was available. The manager told us they had plans in place to implement a proper induction process but that this was not yet done. They showed us a 'new agency induction form" designed for this purpose.

We asked the manager to show us what information agency staff received with regards to people's needs

and care. We were provided with a three page Tabley-Agency Quick reference Guide. This guide was basic and did not contain any details of the people who lived in the home and what their care needs were. It also failed to provide agency staff with any information on health and safety such as fire safety and evacuation procedures. We raised concerns about this with the manager. The manager acknowledged the information provided to agency staff and the information they had access to about people's needs and care was poor. This placed people at risk of unsafe and ineffective care.

This was a breach of Regulation 18 of the Health and Social of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as agency staff had not received an induction or information about the service that prepared them for their role.

We looked at the arrangements in place to support permanent staff to do their jobs effectively. We found these arrangements to be satisfactory. There was evidence that staff had received adequate supervision and appraisal in their job roles. They also had access to suitable training courses to keep their knowledge up to date. We saw that there were gaps in the training for some staff members for example, a number of staff had not completed up to date emergency first aid at work training but overall the majority of staff had completed adequate training.

People's comments about the skills and experience of staff included "It's all right; very nice indeed. I hope they know what they're doing"; "The staff are compassionate and knowledgeable; they're properly trained know what they're doing and what I need." and "The care's very good; they're properly trained and seem to know what they're doing". "The care is good, but not very good. The new ones are not properly trained. Most of the staff are friendly but some appear not to know what they're doing sometimes. They don't understand I don't need help".

Requires Improvement

Is the service caring?

Our findings

People did not always receive the care and attention they needed from staff to keep them safe, promote their independence and ensure they had a good quality of life. This did not demonstrate that the service was caring at all times. For example, some people did have not call bells in place to call for help and no adequate strategies had been put into place to ensure these people were able to summon help when needed. Some people were not given a sufficient or appropriate diet to maintain their well-being and some people sustained injury due to a lack of adequate supervision and support.

During our visit, we saw that one person who lived with advanced dementia was sitting in a chair by the door with no slippers on and listening to music on a CD player that kept sticking. The lady was distressed. There were no staff with this person and the person was sat on their own outside away from the communal lounge. We asked a member of staff to support this person.

In one of the lounge areas we observed eight people sitting in wheelchairs or armchairs with no staff present. The television was on but there was little other stimulation or activity. These people had no means to access their own bedrooms independently. We were told by the nurse on duty that there were only two care staff on duty and they were currently assisting another person with their personal hygiene. This meant these people were left without adequate support or supervision.

We saw that staff were advised to bring two people to the lounge each day so they could be closely observed. There was no evidence that any consideration had been given to whether either person wanted to be brought to the lounge each day or if they wished to spend time in their bedroom or other areas of the home. This did not show the service cared that people's wishes or preferences were considered.

Some of the people told us that the staff team supported them to be as independent as possible. One person said "I'm an independent sort of person; fortunately the staff encourage me to do whatever I can". Another person told us "I can walk about my room with the frame. Staff sometimes suggest that I do something but then I might not be able to do it. However, they know that, if I want help, I will ask".

Some people's ability to be independent however was hindered by the environment. The home was not dementia friendly which meant that some people may have had difficulty finding their way around the home of their own accord or identifying the purpose of a room for example dining room, toilet or their own bedroom.

One person who used a wheelchair to mobilise around the home also told us "The ground here (outside of the home) is not sufficiently level for my electric chair so I can only go round just outside the house". This meant this person's independence to access the gardens and outside area of the home was hindered. It also meant that other people with mobility difficulties would also find it difficult.

These issues indicated that people did not always receive care that met their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relationships between people who lived at the home and staff appeared calm and relaxed. We observed staff speaking with people in a compassionate and kind manner. Staff were patient and kind when they interacted with people but their interactions tended to be task based.

Everyone we spoke with us that staff were kind and respectful towards them. People's comments included "They're kind and considerate; they don't upset me"; "They're very kind"; "Lots of them are kind and considerate; "Yes, lovely" and they are "Very, very kind. Nothing is too much trouble".

People who lived at the home told us their right to privacy and dignity was respected. Their comments included "I can always go to my room if I want privacy"; "The lock on my door ensures my privacy" and "Yes, most people (staff) knock on my door and wait to be invited in". We saw that people's bedrooms were personalised with the items that were important to them. One person said "Of course I am comfortable. I've got all my own furniture: my own bed, my own settee, my own chairs and so on".

The relatives we spoke with told us they could visit when they wanted to and that they were always made to feel welcome. A relative told us "Without a shadow of a doubt I'm made welcome".

The majority of the relatives we spoke with felt people were well-looked after. One relative told us "It's done them (the person) a world of good being here. Hairdresser once week. Staff keep an eye on their nails. They are kept very clean. No problems and I am not alarmed in any way. I can't speak too highly of the care that [name of relative] has received. I have every confidence in the way in which they are being cared for".

Records showed that resident meetings took place and that people were asked about their opinions on the service. People's satisfaction with the service was also sought through the use of a satisfaction questionnaire. The last survey was conducted in April 2017 and generated positive results.

People's care records were stored and maintained on a secure electronic care system that staff could access to input information about people's day to day care. A computer and an Ipad were available in the office for staff to use. The system was password protected which ensured that people's personal information was kept confidential. Other documentation in relation to people's care was also stored in a small office which was locked at all times.

Inadequate

Is the service responsive?

Our findings

People's care records were designed around their individual needs. Most of the information in people's care files focused on the tasks that people needed support with as opposed to their preferences and wishes with regards to their care. Some of the information with regards to people's needs was also unclear.

For instance one person was 'confined to a wheelchair at all times' and unable to walk. Staff were advised to use either a hoist or a stand aid to assist their mobility in one section of the care plan and told that the person required assistance to move from a sitting to standing position and a standing to lying position in another section. This was confusing as the person was unable to stand to complete any transfers and a stand aid should not be used for people who are unable to weight bear. This placed the person at risk of unsafe and inappropriate care.

One person lived with dementia that sometimes meant they experienced hallucinations. Despite this staff had no information on the type or severity of hallucinations the person may experience for example auditory or visual hallucinations. There was also no person centred guidance given to staff on how best to support the person when these hallucinations occurred.

Where people experienced behaviours that challenged, staff had little guidance on how to support them in a person centred way. There was little information on what triggered people's episodes of distress, or challenging behaviours or the strategies staff should use to support the person to reduce their agitation. This placed people at risk of receiving care that was inappropriate and did not meet their needs. For example, one person's challenging behaviours were described as 'extreme risk'. The person's risk management plan advised staff to use "planned interventions" but failed to advise staff what these were. The person's daily records showed that 19 incidents of physical and verbal aggression had occurred towards staff during a six day period.

Other aspects of people's care were not provided in a way that met their needs and risks. For example, some people were assessed as being at high risk of pressure sores. Staff were advised to ensure people were repositioned regularly to prevent a pressure sore from developing. For some people a time period of two to four hourly repositioning was clearly identified. People's care records however failed to show that they received the repositioning support they needed. We asked the manager about this. They told us "No-one is on repositioning pressure care at the moment". This was clearly not correct, as people's care records clearly indicated that some people needed this support to maintain their skin integrity.

Some of the people who lived at the home required the use of a hoist and sling to support them to move and transfer position. One person's relatives told us that they had previously told the manager and staff that the sling being used was not the right one and caused the person discomfort. They said a new sling had been purchased but staff continued to use the 'old' one. During our visit, we observed staff using the old, incorrect sling when transferring the person from their wheelchair to a chair. We asked two nurses which sling was to be used to support the person and they told us the wrong one.

We asked two nurses and a carer what hoist and sling they used to support another person who lived at the home. Only the carer was able to tell us the correct one, both nurses did not know which sling was the right one to use. This lack of adequate knowledge of people's individual moving and handling needs placed people at risk of receiving unsafe care that did not meet their needs.

Some people had pressure relieving mattresses in place to help prevent a pressure sore from developing. We checked people's mattress settings. Four out of the five people's pressure mattress settings we checked were incorrect. Two people's pressure mattress setting were too low for their needs and two people's settings were too high. Too high or too low a pressure setting for a person's weight can increase their risk of developing a pressure sore as opposed to preventing it. This did not show that people's care was provided in a safe way.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the support provided was safe and met people's needs.

There was some information in people's care records about their preferences, wishes and likes and dislikes but this information was limited. For instance people's care files stated whether the person preferred a bath or a shower but information about their dietary likes and dislikes was limited. Some of the guidance given to staff in the delivery of care also did not correspond with their preferences. For instance, one person's care file stated that they preferred to have a bed bath or strip wash each day. The guidance given to staff however advised staff to offer the person a bath or shower each day.

We asked people if they thought staff knew what they liked and disliked. People's comments included "I think they've got me sewn up very well indeed. Possibly one doesn't think much of me but staff love me and I love them"; Yes, I think so and "Yes, most of them know me quite well. They know that, if I want help, I'll ask for it".

One person told us "No, I don't think they know me well. They're not used to limbless people; they don't understand that I do my own thing." A relative we spoke with said "I would like to know more about what happens in the night – getting up/wandering as they (the person) do at home. Staff don't seem to know. It is important to know this as it led to a fall at home'.

Care plans and risk assessments were regularly reviewed but there was little detailed information about the person's progress or evidence that the person and their family had been involved in reviewing their care. We asked some of the people we spoke with if they had been involved in care plan reviews. All of them said no.

We saw that health and social care professionals were involved in some people's care but found that some people's needs were not always identified or acted upon with the priority they required. For example, some people experienced multiple falls but referrals to the falls prevention team or occupational therapy had not been made in a timely manner. Some people experienced weight loss but referrals to a dietician or speech and language therapist had not been facilitated. This meant the support provided failed to identify and proactively respond to changes in people's needs.

These issues indicated that people did not always receive the person centred care they needed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with felt staff would get the doctor immediately if they were unwell. People had access to routine healthcare appointments with a chiropodist, dentist and optician.

Four activity co-ordinators were employed at the home. There was a full programme of activities displayed including: baking and making cards, quiz time, talk of past times, a sherry morning, flower arranging, arts and crafts, Holy Communion, gentle exercises, a pub lunch at a local pub, afternoon trip to a garden centre and an opportunity to attend a tea dance. One person said "There's always something going on". Another said "We have animals that come – a snake, monkey, tortoise. There's a very nice activity lady who does my nails and a third person.

There were some one to one activities available for people who lived with dementia to participate in. We saw that there was an activity schedule in place for these people but it did not provide detail of what activities were provided. There it was difficult to gauge their value.

The provider had a complaints policy in place. People we spoke with knew how to make a complaint and felt positive they would be listened to. Two people told us they had previously made a complaint and said that they had been dealt with appropriately by the manager. One person's relatives raised serious concerns about the care their loved one received at the home during our inspection. We discussed these with the manager and deputy manager. The person's relatives subsequently withdrew their complaint. None of the other people we spoke with had any formal complaints about the care they received on the day of our visit.

Inadequate

Is the service well-led?

Our findings

Most of the people we spoke with felt the service was managed well. During our visit we found that this was not always the case as serious concerns with people's care and the management of the service were identified.

The systems in place to assess, monitor and mitigate risks to people's health, safety and welfare were ineffective. The level of managerial and provider oversight was insufficient to recognise and respond to the concerns we identified during our inspection which should have been picked up and addressed prior to our visit.

Providers are required by law to notify CQC of certain events which occur in the service. Records indicated that the provider had failed to notify CQC of several notifiable events.

There was a range of quality assurance checks in place to monitor the quality and safety of the service. For example, monthly and quarterly medication audits, monthly care plan evaluations, quarterly infection control audits, sling and hoist checks and a maintenance book that was checked twice daily. We found some of these audits to be ineffective.

Medication audits were not always accurate. For example, we looked at the controlled drug (CD) audit for the period January to March 2018. The audit stated that 100% compliance with CD requirements had been achieved. Yet other records showed that during this period a quantity of CD medication was unaccounted for and had to be reported to CQC and the GP practice.

Quarterly infection control audits were not always accurate. For example, in February 2018, a month prior to our visit, an audit was undertaken which determined the home was 100% compliant with infection control standards. On our visit, we found that improvements were required. Some of the bedrooms in the home smelt offensively, one of the pressure cushions we saw in use was cracked and chipped which would have made cleaning it difficult and the clinical storage room in the basement was unclean.

People's care plans and risk assessments were sometimes confusing and unclear which placed people at risk of inappropriate and unsafe care. People's monthly care plan evaluations had failed to pick this up and were therefore ineffective. Other records in relation to people's care were poorly completed.

For example, accident and incident forms were not completed in full and some answers were pre-populated. There was also no evidence that they had been reviewed by the manager to ensure appropriate action had been taken to prevent further risk. People's food and drink charts were poorly completed and there was no evidence that nursing staff checked this documentation to ensure people received enough to eat and drink. There was also no evidence that people's daily care records were checked or monitored to ensure people received the care they needed.

Staff recruitment failed to be robust as the provider's recruitment policy had not been properly followed.

Staffing levels in the home needed to be reviewed to ensure that they corresponded with the dependency levels identified by the provider and the concerns identified with people's care during this inspection.

We asked the manager if the provider audited or visited the service. They told us their senior manager visited and that a clinical oversight group came in and audited the service. There was no evidence of any clinical audits undertaken. We asked the manager if they had supervision with their line manager. They told us they did not have formal supervision but that they did 'have chats' with their line manager. This did not demonstrate that the senior management team and provider had sufficient oversight of the service in order to support the manager in her job role.

These examples are all breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the governance arrangements at the home were poor.

During the inspection we asked the manager to refer the concerns we had about some people's care to the local authority safeguarding team and to make urgent health and social care referrals for those people whose well-being we were concerned about. The manager acted upon this without delay.

We asked the manager and provider for an urgent action plan to be put into place to mitigate the immediate and serious concerns we had identified with regards to the provision of safe and appropriate care (Regulation 12 of the Health and Social Care Act). An action plan was submitted and we saw that the senior management team was to be involved immediately with supporting the service to make the necessary improvements. This assured us that some of the risks we had identified were being acted upon immediately in order to protect people from harm.

We saw that staff meetings took place regularly to discuss issues associated with the running of the service. A staff survey also took place annually. A quarterly meeting with the home's GP took place to discuss the service for instance types of admissions to the service and admissions to hospital from the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs, preferences and wishes were not properly assessed or considered with regards to the person's plan of care. This meant there was a risk they would not be respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's needs and risks were not always properly assessed and managed. Medicines were not always administered safely or in accordance with PRN protocols.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were no robust systems in place to record, investigate, act upon and protect people from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care

Treatment of disease, disorder or injury

proper persons employed

Staff recruitment procedures were not always robust or operated effectively to ensure staff were suitable to work with vulnerable people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent had not always been assessed and the use of restrictive practices had not been considered with in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were not always effective in assessing, monitoring and mitigating the risks to the health, safety and welfare of people who used the service.

The enforcement action we took:

We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not always sufficient to ensure people's needs were met at all times. Agency staff had not received an adequate induction into their job role or sufficient information about people's needs in order to provide safe and effective care.

The enforcement action we took:

We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.