Eldercare (Halifax) Limited

Elm Royd Nursing Home

Inspection report

Brighouse Wood Lane
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West Yorkshire
HD6 2AL

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5 and 8 June 2017 and was unannounced. At the last inspection on 13 and 20 December 2016 we rated the service as 'Inadequate' and in 'Special Measures'. We found six regulatory breaches which related to staffing, nutrition, safe care and treatment, dignity and respect, person-centred care and good governance. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Prior to this inspection concerns had been raised by the local authority and clinical commissioning group (CCG) regarding the clinical management of the home. These concerns had been discussed with the provider who agreed to a voluntary suspension on admissions to the home and additional nursing staff were provided by the CCG in April 2017 to work alongside the home's own staff providing clinical support and guidance. On 1 June 2017 the additional nursing staff supplied by the CCG were withdrawn at the request of the provider following the transfer of eight people from Elm Royd to other services. The voluntary suspension on admissions was still in place when we carried out this inspection.

Elm Royd Nursing Home is registered to provide nursing and residential care to up to 50 older people, some of who may be living with dementia. On both days of the inspection there were 29 people living in the home, 28 who required nursing care and one person who required personal care. Accommodation is provided on two floors in single rooms with en-suite facilities. There are communal areas on both floors.

At the time of the inspection the home did not have a registered manager. A manager had registered with the Care Quality Commission in January 2017, however they left their post in April 2017. A manager from one of the provider's other services was managing the service when we inspected. 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.

Although people we spoke with told us they felt safe we found there were insufficient staff to meet people's needs and keep them safe. For example, on the second day of the inspection we saw some people did not receive their morning medicines until 12.30pm as there was only one nurse on duty when previously there

had been two. The night staff told us they had been told to get more people up to help the day staff and were concerned as this meant people had to be washed and dressed very early in the morning. We saw periods of up to an hour when no staff were present in communal areas.

Risks were not well managed which placed people at risk of injury or harm. For example, we saw one person had a severe choking episode after eating bacon, fried bread and sausage when they were supposed to have a soft diet because of swallowing difficulties. Staff were not aware this person required a soft diet.

Medicines were not safely managed which meant we could not be assured people were receiving their medicines as prescribed.

Safe recruitment processes were in place and new staff received induction, however we found this often took place several weeks after the staff member had started work. Staff received ongoing training however this was not always kept up to date and supervisions had lapsed although the manager told us they had a plan to address this.

We saw current certificates showed the safety of the gas supply, portable appliance testing, electrical wiring and fire systems. However, weekly checks of emergency lighting, door guards and water temperatures had not been completed since 10 May 2017.

Staff were aware of safeguarding procedures and were confident any abuse they reported would be dealt with appropriately.

The requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were not being met as we found conditions which had been applied to DoLS authorisations had not been complied with.

Most people said they enjoyed the food although we found the meals identified on the menus were not always been served. We found people's dining experiences differed depending upon whether they were on the ground floor or the first floor. For example on the ground floor people were offered a choice of food and drink which did not happen on the first floor.

Where people's food and drink intake was being recorded there were no systems in place to review these records to ensure people were receiving sufficient to eat and drink.

People praised the staff and said they were kind and caring. However, we observed practices which showed a lack of respect for people and compromised their privacy and dignity.

There was conflicting information about people's care needs and care plans did not always reflect accurately the care people required, putting people at risk of receiving inappropriate or unsafe care. People had access to healthcare services.

People told us they knew how to make a complaint and we saw records which showed complaints had been investigated and the complainant had been informed of the outcome.

We found there was a lack of consistent and effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. This was evidenced by the continued breaches we found at this inspection. We identified seven breaches in regulations – staffing, safe care and treatment, dignity and respect, nutrition, person-centred care, consent and good governance.

Following the inspection we made safeguarding referrals to the local authority safeguarding team and had discussions with the CCG and local authority commissioners. Due to the seriousness of our concerns the CCG and the local authority took immediate action to provide additional support into the home and worked with the provider to ensure all people accommodated in the home were moved to alternative accommodation by 16 June 2017.

The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service therefore remains in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines management was not safe and effective, which meant we could not be assured people received their medicines as prescribed.

Staffing levels were insufficient to meet people's needs in a timely manner. Staff recruitment processes were robust as checks were completed before new staff started work to ensure their suitability to work in the care service.

Risks to people's health, safety and welfare were not assessed and mitigated. Safeguarding incidents were dealt with and reported appropriately.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received the induction, training and support they required to fulfil their roles and meet people's needs

The service was not meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not always met.

People's healthcare needs were assessed and staff supported people in accessing a range of health professionals.

Is the service caring?

Inadequate

The service was not caring.

Although people told us staff were kind and caring, our observations showed people's privacy, dignity and rights were not always respected and maintained by staff.

People were not consistently supported to meet their cultural

needs.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were not always accurate and conflicting information meant people were at risk of receiving inappropriate care.

Some people enjoyed the activities provided however we found for others there was little to stimulate or occupy them

Systems were in place to record, investigate and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and management of the service was not consistent or effective. The registered manager had left and a manager from one of the provider's other homes was managing the service.

Quality assurance systems were not effective in assessing, monitoring and improving the quality of the service and we found regulatory breaches identified at the previous inspection had not been met.

Elm Royd Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 8 June 2017 and was unannounced. On the first day the inspection was carried out by three inspectors, a pharmacist inspector and an expert by experience with experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day three inspectors attended.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and the clinical commissioning group (CCG).

We observed how care and support was provided to people. We spoke with eight people who were living at the home, four relatives, three nurses, twelve care workers, the manager and the area manager.

We looked at ten people's care records, four staff files, eight medicine administration records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Our findings

At the last three inspections we found systems and processes in place to manage medicines were not safe or effective. At this inspection we identified similar concerns.

We looked at medicines administration records (MARs) and spoke with two nurses responsible for medicines. The MARs had individual photographs and allergy details; this helps to prevent medicines being given to the wrong person or to a person with an allergy. Of the eight MARs we reviewed, we found missing signatures in four of them. This meant it was not always possible to tell what medicines people had received. Some people were prescribed medicines to be taken when required, or 'PRN'. We found there was a lack of supporting information to guide staff how to administer these medicines safely. We checked stock balances of medicines and found they were not always correct. In addition, in two cases there were not adequate supplies of medicines to meet the needs of the individuals concerned.

One person was self-administering their own inhalers. No risk assessment had been completed to assess whether the person was able to do this safely. In addition, the person's medication care plan stated they required qualified staff to administer their medicines at all times. This meant we could not be sure the person was being adequately supported to take their medicines safely.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. Topical MARs were in place to record the application of these medicines, however in four cases the MARs showed care staff had not applied them as prescribed. In addition, body maps had not been filled in to guide staff where to apply the cream or ointment.

Two people were prescribed fluid thickeners to be added to their drinks to reduce the risk of choking. In both cases, care staff we spoke with were unable to tell us the correct amount of thickener which should be added to their drinks, despite this information being recorded in people's care plans. In addition, we observed care staff using thickener which had not been prescribed for the individual. Using fluid thickener incorrectly increases the risk of choking. We also found care staff did not record when thickener had been added to drinks. This meant records did not reflect the treatment people had received.

We checked medicines which required refrigeration and found temperatures had been recorded for the fridge on the upstairs unit which were outside of the recommended range for storing medicines and no action had been taken. In addition, maximum and minimum temperatures had not been recorded on both units every day in accordance with national guidance. This meant we could not be sure the medicines

stored in these fridges were safe to use. In addition, we found ambient temperatures had been recorded for the medicines storage room on the downstairs unit which were above the recommended limit on 20 days in May 2017. This had not been risk assessed or any advice sought to ensure medicines stored in this room would be safe to use. Storing medicines at temperatures higher than those recommended by the manufacturer increases the risk of the medicine becoming less effective.

We reviewed monthly medicines audits, the last of which had been carried out on 17 April 2017. These audits were limited in scope and did not cover all aspects of safe medicines management. In addition, staff did not always complete all of the audit questions. Audits for both units had identified shortfalls in the management of medicines, however not all of these had been included in the resulting action plans. In addition, we found actions from previous audits had not been followed up to ensure they had been completed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely and access was restricted to authorised staff. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. We saw evidence of regular balance checks of controlled drugs.

At our previous inspection we found there were not enough staff on duty to meet people's needs and we identified the same concerns at this inspection. The week before our inspection the occupancy levels had reduced as eight people had moved out of the home. The manager told us they had reviewed and reduced the staffing levels after taking into consideration people's dependencies and feedback from staff. However, they were unable to provide any documentary evidence to show how the staffing levels had been calculated to ensure they were sufficient to meet people's needs and keep them safe.

On both days of the inspection we observed there were periods of time when no staff were present in communal areas where people were sat. The manager told us the staffing levels were one nurse and six care staff between 8am and 8pm and one nurse and three care staff at night. The manager said some people who had rooms on the first floor were now being brought downstairs to spend the day in the communal areas on the ground floor. When we asked how it had been decided who would go downstairs the manager said they had asked people. We observed this arrangement was not working well. One person we spoke with who had been brought downstairs told us they did not like it and preferred being upstairs. A relative told us they had noticed a difference since the staffing levels had been reduced and said staff were very busy. They described the lunch time experience in the downstairs dining room as 'horrendous' as there were not enough staff and it was very noisy which impacted negatively on their relative. We heard one person in the downstairs lounge shouting for a nurse, when we went in a visitor told us three staff had been in and said they would come back but no one had. We found a staff member who went to assist the person.

Although people we spoke with told us they felt safe, staff raised concerns with us about the staffing levels, particularly at night as staff said they had been told to get more people up to help out the day staff. Staff were concerned as this meant people would have to be washed and dressed very early in the morning. One staff member told us, "It's not right I wouldn't want that to be happening to my relative." When we arrived on the second day at 7.30am there were eight people up and dressed. On the first day of the inspection there had been two nurses on duty however on the second day there was only one nurse. We saw this impacted on the care people received, for example the morning medicine round was not completed until 12.30pm which meant people did not received their medicines in a timely way. We saw the nurse was continually interrupted to deal with other issues such as assisting a person who was choking and arranging GP visits. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found there were not effective systems in place to assess, monitor and manage risks to people and keep them safe. At this inspection we found this had not improved. We saw risk assessments were in place in people's care records for areas such as nutrition, pressure area care, falls and moving and handling and some care plans contained guidance for staff on how to mitigate the risks. However, we found staff were often unaware of identified risks and the care or support needed to mitigate them. For example, one person's care records showed they were at high risk of choking and required a soft consistency diet. On the second day of the inspection we saw this person choking after they were given a cooked breakfast of bacon, sausage, fried bread, beans and egg. Three staff members who were on duty, which included the chef and a senior care worker, did not know the person required a soft consistency diet. We saw a list of specialist dietary requirements displayed in the kitchen, which the manager told us had been updated that day, which stated incorrectly that the person had a normal diet. We saw another person's risk assessment showed they needed to be repositioned every two hours as they were at high risk of developing skin damage. We saw this person sat in a wheelchair in the same position for over five and a half hours. Although there was a current fire risk assessment for the home there was little documented evidence to show staff had participated in fire drills. A provider visit report dated February 2017 had identified fire drills needed to be carried out, yet the only evidence to show this had been acted upon was a handwritten note dated 3 March 2017 which stated three staff had attended a fire drill. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw up to date environmental risk assessments were in place. We saw current certificates confirming the safety of the gas supply, portable appliance testing, electrical wiring and fire systems including the alarm, fire extinguishers and emergency lighting. However, weekly checks of emergency lighting, door guards and water temperatures had not been completed since 10 May 2017. The manager told us the staff member who carried out these checks had been off sick and they had someone else coming in that day to do the checks.

Recruitment files we reviewed showed all the necessary checks were carried out before new staff started work to ensure their suitability to work within the care service. This included criminal record checks and employment references. We saw evidence which showed checks were made to ensure nurses had current registration with the nursing and midwifery council (NMC).

Staff we spoke with were aware of the safeguarding procedures and were able to describe the different types of abuse which may occur. Staff told us they would report any concerns about people to the manager and were confident these would be dealt with appropriately. We saw records which showed safeguarding incidents had been identified and referred to the local authority safeguarding team.

Inadequate

Our findings

At our last inspection we identified concerns relating to the training and support staff received. We found similar concerns at this inspection.

The manager told us new staff completed six days training which included dignity, choice and diversity, safeguarding, dementia awareness, infection control and mental capacity and a minimum of one week shadowing experienced colleagues. However, we found new staff received this initial training some weeks after they started in post. For example, one staff member who started in February 2017 did not start their six days training until April 2017. Another recently recruited staff member told us they had no previous care experience and said when they had started work they had shadowed a senior care staff member for two days and had received a week's induction a couple of months after they had started in post. The area manager told us once new staff had completed the six day training their competency was checked through supervision and observation. However, when we asked to see records of these checks for new staff recruited in 2017 the area manager advised there were none.

Staff we spoke with said they received appropriate training which had helped them understand how to do their job properly. The training matrix confirmed this although there were areas highlighted where staff members were overdue refresher training. For example, 20 staff had not received an annual update in safeguarding, 17 in moving and handling and five in fire safety. The matrix also had gaps where there were no training dates for some staff. This meant we could not be assured all staff had received the training and updates they required for their roles.

Staff we spoke with said they received support although they did not receive regular formal supervision. One member of staff said, "Supervisions are not happening. They do them if there are performance issues but not routine." Staff files we looked at lacked evidence of supervision and appraisal meetings. When we asked the manager about this they told us these activities had been very limited. They said, "It would be easier to say they had not happened." We saw the provider had identified improvement was required in this area, and the manager showed us the plan they had put in place to ensure staff received timely supervision in future. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw records which showed when DoLS applications had been made and authorised. However, this record did not include one DoLS authorisation which we saw had expired and no renewal had been requested. We informed the manager who was unaware the DoLS had expired and submitted a request for a renewal during our inspection. Staff understood that people's capacity had to be taken into account when decisions were made. One staff member provided examples where two people were making unwise decisions. However, staff told us they were unsure who had an authorised DoLS.

Some DoLS had conditions the provider was expected to adhere to in order for the deprivation to be lawful, and we found these were not always being met. For example, we saw one condition stated the person should be encouraged to have variety in their routine relating to time they spent in bed and in communal areas during the day. We looked at the person's activity records for May 2017 and found the person had a repetitive routine. Of fourteen days where records had been kept we saw the person had spent the afternoon in bed. On the other four days it was not recorded what time of day an activity had taken place. Another person's DoLS had a condition stating best interest decisions should be completed for various aspects of their daily experience, for example use of bedrails, dietary adaptations and medicines administration. There was no documentary evidence of best interest decisions in the person's care plan. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us they liked the food, although one person told us they felt food choices were limited and another person said they found the beef tough.

On the first day of the inspection the cook was absent and one of the catering staff who did not usually prepare and cook meals covered at short notice. They told us they had done this previously. They explained they did not follow the menu because they were late starting the shift and did not know how to prepare all the meals on the menu. We looked at food records and menus which showed the meals served often varied from the menu option. The food records listed the main meal and temperature these were served, however we noted these were not consistently completed so sometimes we could not establish what had been served. The service had a three week menu, which offered two alternative main meals at lunch and two lighter options at 'tea'. Desserts were offered at both meals. Menu one indicated at lunch people could choose, for example, lamb hotpot or cod mornay; cottage pie or sausage meat loaf; chicken and dumplings or mince and onion pie, beef lasagne and garlic bread or hunter's pie. We looked at the food records for the week this menu option should have been offered and saw only three out of the seven days had been completed. Two of the menu options recorded matched the menu; one did not. Failure to follow the menu or record and monitor meals provided meant that the provider could not make sure people maintained a balanced diet or were involved in decisions about what they ate. The provider could not be sure food was served at the correct temperature.

We observed lunch in the dining rooms on both floors and found a difference in how this was managed. On the ground floor we found there was a relaxed atmosphere and people were offered a choice of food and drink. On the first floor there were three people in the dining room. The table was not laid and there was no tablecloth, napkins or mats. People were not asked what they would like and the meal was given to them

already plated. The meal was fish, chips, broccoli and mixed vegetables. No condiments were available or offered. Two of the people were not given any cutlery and when we asked staff why they said they had asked and neither person wanted cutlery as they ate with their fingers. We had not seen or heard staff ask either person if they wanted cutlery. We had seen one of these people using cutlery to eat their breakfast in the morning. Each person was given a hot drink, no cold drinks were offered. Forty minutes after the main course had been served people were still waiting for their dessert.

We observed people were offered regular drinks throughout the day. Staff encouraged people to drink with their meal and in between meals. Staff told us people had access to drinks and snacks at any time during the day or night. They also said people had milkshakes every evening which were high in calories and helped people who underweight or at risk of losing weight.

We saw food and fluid charts were in place for people who were low weight or identified as nutritionally at risk. The charts we reviewed were poorly completed and had not been monitored or reviewed by staff to ensure people were receiving sufficient amounts to eat and drink. We saw staff did not complete the charts at the time people were drinking but later in the day and often the same amount of fluid, 200mls was recorded each time. We concluded the provider could not be confident the food and fluid charts were effective and accurate. The nurse told us they checked the charts but acknowledged no records were made of these checks. We saw one person's care records showed they were low weight and had a low body mass index. Their food and fluid charts recorded very little dietary intake on some days, yet there was nothing recorded to show this had been identified or addressed by staff. We had identified similar concerns at our previous inspection. This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records showed people had input from different healthcare professionals such as GPs, community matrons, chiropodists and opticians. However, we found staff were not always following the advice given by healthcare professionals. For example, the speech and language therapist (SALT) team had advised one person was to have a soft consistency diet yet this was not being provided by staff.

Inadequate

Our findings

At our previous inspection we found people's privacy and dignity was not always respected and we identified the same concerns at this inspection.

People who used the service and relatives we spoke with praised the staff who they said were kind and caring. One person said, "The best thing is the staff, because they are good, they come in do what they have to do and make sure you are ok, they are very good." A relative said, "I can't say anything bad about it, the staff are nice and helpful."

However, we found there was a lack of consistency in how people were treated by staff and observed people had different experiences. For example, on the first day of the inspection we found people who resided on the ground floor had a pleasant experience. A senior care staff member spent most of the day in the communal areas. They were attentive to people's needs and responded to any request for assistance promptly and with a friendly manner. They offered people drinks, encouraged people to engage in activities and spent time chatting to people. It was evident from people's responses they enjoyed the interaction from this staff member. One person requested to leave the dining room. A member of staff explained they had not yet finished their meal but the person repeated that they wanted to go to their room. The member of staff respected their wishes and we saw the person finishing their meal in their room.

In contrast, on the first floor we saw people brought into the upstairs lounge and positioned in seating without being offered a choice of where they would like to sit. We saw staff providing people with assistance to eat meals without engaging with them. One person was not asked which part of the meal they wanted and another person's meal was interrupted on numerous occasions by staff breaking off to provide assistance to colleagues and other people. We saw one person was sat in their wheelchair in the dining room from when we arrived at 7.30am until 1pm.

We observed a number of occasions when people were left in communal rooms with no staff presence and no means of accessing call bells. For example, on the second day of our inspection we saw the call bell in the upper floor dining room was mounted on the wall. There were hoists stored in front of it, and the people in the room were using tilt chairs which prevented them from moving across the room to summon help if they had needed to. From 8.40am to 9.20am both people were in the dining room with no staff presence. At 9.20am staff came into the room and asked one of the people if they wanted any breakfast. The second person was not given any breakfast until 9.45am. Following breakfast both people were left with no staff presence in the room from 9.55am to 10.55am, when a member of staff came into the room and sat in a

chair completing paperwork. The staff member did not speak with either person before leaving the room at 11am.

On the second day of the inspection we heard a person screaming very loudly in their bedroom. The door was closed, we knocked and entered and saw the person sat in a chair very agitated and distressed. We spoke with the person who became quiet. We put the doorguard on so the door would stay open and went to find staff; as we walked away the person began screaming again. We found the manager round the corner from this person's room and expressed our concerns about the person. We had reviewed the person's care plan previously which had shown the person preferred to stay in their room but liked to have the bedroom door open and to listen to CDs. The manager told us the pitch of the person's screaming activated the doorguard causing the door to close automatically, they said there was nothing they could do to keep the door open. We expressed our concerns that the person was clearly distressed and advised the manager they needed to take action to alleviate this. Shortly afterwards we saw the activity organiser sat with the person chatting quietly, massaging the person's hands with music playing in the background and the bedroom door open. The person was settled and calm and remained so after the activity organiser had left the room. We were concerned that no staff, including the manager, had responded to this person's evident and audible distress until we requested the manager to take action.

On the second day of the inspection night staff told us they had run out of continence pads for people. They showed us packets of small sized pads which they said they were having to use for everyone regardless of their individual continence needs. Staff were upset as they described how this compromised people's dignity and said it was not the first time this had happened. We saw people's care plans described the different types of pads they required during the day and at night. For one person we found no supply of pads, for another there were none of the night pads they required. We discussed this with the manager and area manager. The area manager confirmed the home had run out of pads six days previously and said they had brought in additional supplies. They said staff had advised they had run out again and the area manager said they had brought in more supplies which we saw a staff member unloading from the area manager's car when we left. Continence products are prescribed for individuals according to their assessed needs and supplied on a regular basis by the continence service to ensure people have sufficient supplies. The area manager was unable to explain why people had run out of continence pads and told us this was being investigated.

The quality of information in people's care plans varied. We saw some contained personalised information which included information about the person's childhood, adulthood, family, interests and hobbies. This helps staff develop an understanding of the person.

We looked at one person's care file which showed they enjoyed a 'bath as opposed to a shower' and would 'generally let staff know when' they would 'like a bath'. The guidance stated 'staff may need to encourage at times especially if' they haven't 'had one for a while'. We looked at the daily records between 1 May 2017 and 4 June 2017 but there was no evidence to show the person had had a bath or a shower. A senior member of the care team said there was no other record of baths or showers maintained.

We observed on the first day of the inspection the door of the nurses' office was left wide open; care plans were kept on a shelf and could be accessed by anyone. This did not ensure people's information was kept confidential.

Providers are required to take account of the protected characteristics set out in the Equalities Act 2010. At the last inspection we found there was an inconsistent approach to identifying and supporting people's cultural needs and provided an example about one person whose first language was not English. Staff were

not able to tell us with any certainty what the person's first language was. At this inspection we found action had still not been taken action to identify or meet this person's cultural needs.

This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Our findings

At our previous inspection we found people's care plans were not person-centred, up to date or accurate. At this inspection, although new care documentation had been put in place we found similar concerns.

We found inconsistencies in care records about people's needs which put people at risk of receiving unsafe or inappropriate care. For example, the handover sheet stated one person had a DoLS authorisation in place, yet when we checked the care records this had expired. It said another person had their medicines covertly but when we checked with staff they said they didn't and stated another person was on thickened fluids but again care records showed they were not. Another person's care records showed a community matron had given specific hygiene advice to manage a medical condition yet there was nothing in the care plan about this. An infection control nurse had advised another person was a carrier of Clostridium Difficile bacteria and staff needed to inform the GP if the person had any loose stools, yet this was not in the person's care plan.

We found information about people's health and well-being was not always accurately reported and recorded. On the first day of the inspection one of the night staff described the previous night as a 'loud shift'. They said three people had been unsettled; two of them had wanted to get up during the night and one had been 'noisy'. Yet this was not communicated to the day staff. We attended the handover session and heard night staff tell the day staff everyone was settled. We saw the handover sheet recorded all three people were 'settled' and 'slept'. We looked at one person's notes which stated they 'didn't get much sleep'. And had 'an unsettled' night as they 'kept getting up and asking if it was time to get up'.

On the second day of the inspection we saw an entry in one person's daily records dated 5 June 2017 which stated the person 'has had a settled morning in (their) room'. We had seen this person on 5 June 2017 and they had been in the dining room from 7.30am until 1pm.

We found people's care plans detailed support people required however we found this was not always happening in practice. For example, one person's care records showed they had lost 4kgs in weight between April and June 2017 and their nutritional care plan stated to offer snacks and maintain a food diary. Staff told us there was no food diary in place for this person. We raised this with the manager and when we returned on the second day of the inspection food charts had been commenced. Another person's care plan showed they were at very high risk of developing pressure ulcers and needed to be repositioned very two hours. On the first day of the inspection we saw the person sat in a wheelchair for five and a half hours without being repositioned and on the second day for over three hours. This was a breach of the Regulation

9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were aware there were activities taking place in the home. One person told us they didn't like taking part in group activities and weren't able to do any exercise so instead they watched television and enjoyed regular visits from their relatives. Another person said they didn't want to join in with activities but would like to go on trips to the countryside as they used to love going for long walks. They said they hadn't been anywhere since they came into the home.

The provider employed an activity organiser. We saw there was a monthly activity programme displayed in the home which included quizzes, baking, reminiscence, floor games and regular church services. We saw some people were involved in activities. For example, we saw one person playing patience, and another person enjoying some colourful table top activity. On the second day of the inspection we saw a number of people attended a church service held in the lounge on the ground floor. However, we found a lack of consistency as some people were supported with activities whereas for others there was very little to occupy or interest them apart from the television. For example, on the first day part way through the morning staff put on a CD for the people who were sat in the dining room, however, after a short period the CD jammed and the music juddered to halt playing the same refrain over and over causing one person to say, 'What is that? What is it?" No staff were around so after speaking with people we switched the CD player off. When we returned on the second day and went to the dining room where two people were sat, no staff were present and the CD was again jammed and playing loudly the same refrain repeatedly. While we were sat with people in the upstairs lounge the television switched itself off. We asked staff about this and they told us it often happened and they didn't know why.

The complaints policy was displayed in the home. We found three complaints had been received since the last inspection and records we reviewed showed these had been investigated and the outcome had been communicated to the complainant. Relatives we spoke with said if they had any concerns or queries they told staff and they were dealt with efficiently.

Inadequate

Our findings

At our last inspection we identified shortfalls in the leadership, management and governance of the service. Following the inspection the provider sent us an action plan showing the action they had taken to address these issues and improve the quality of the service. However, at this inspection we found continued regulatory breaches which demonstrated the service had not improved. We concluded the service was not well-led.

In April 2017 following safeguarding concerns relating to the clinical management of the service the provider agreed to additional nursing staff being brought in by the CCG to work alongside the home's own staff providing clinical support and guidance. On 1 June 2017 the additional nursing staff supplied by the CCG were withdrawn at the request of the provider following the transfer of eight people to other services.

There was no registered manager in post. The manager who was in post at the time of the last inspection in December 2016 had registered with the Care Quality Commission (CQC) but left the home in April 2017. The high turnover of managers has been a feature of this service for the last three years. A manager from one of the provider's other services was managing the service when we inspected.

Staff we spoke with told us morale was low and said frequent changes in management had impacted on the service. Some staff told us the current management team were approachable and felt they were making improvements. Three staff we spoke with said the managers were visible and visited the service frequently. One staff member said the managers were 'trying to do the best they can'. However, other staff told us they were scared to speak out and said they had raised concerns about staffing levels but felt they were not being listened to.

We looked at minutes from the most recent staff meeting held on 30 May 2017. We saw discussions had taken place relating to staffing levels, medicines management, and changes in numbers of people using the service. The minutes showed concerns had been raised about the staffing levels, particularly the numbers of nurses on each shift with staff saying they didn't think it was safe. The area manager was recorded as having said, 'We can't afford two nurses' and 'Will review staff levels, can't change nurses.'

We saw there had also been a staff meeting in February 2017 relating to the CQC inspection report, a staff briefing in March 2017 to discuss new care documentation, falls management and information about a person due to commence using the service. There had also been a meeting of the nursing staff in March 2017 at which the CQC report, medicines audit and checks on care plans had been discussed.

The provider had an audit plan to measure, monitor and improve the quality of the service which listed the areas to be covered and the frequency of these audits. This included monthly audits of medicines, care plans, accidents and incidents, bedrails, mattresses and complaints. In addition there were quarterly audits scheduled for infection control and radiators, and an annual check on manual handling equipment. However audit records we reviewed showed these were not always happening in line with the provider's schedule. For example, the monthly bedrail audit had last been completed in February 2017, with a note stating 'Same actions as last month.' This meant the previous audit had not been used to improve quality in this area. The monthly wheelchair audit had also not taken place since February 2017, and there was no evidence complaints were analysed to enable the provider to identify emerging trends and ensure appropriate action had been taken. The manager told us, "There would be analysis if there were enough [complaints], but there aren't.' The complaints audit showed in the period from January to May 2017 there had been six complaints recorded, yet our review of the complaint file showed only three complaints in this period.

The records of the most recent provider visit in February 2017 showed a lack of audit activity had been identified. For example, the lack of complaints audit had been identified and we saw the area manager had recorded, 'No audit but complaints in file.' The report also identified that there had been no audit of accidents and incidents.

We looked at the accident and incident reports for the previous three months and found a significant increase in the numbers that had occurred in May 2017. For example, the reports showed 10 accident and incident reports for March 2017 and ten for April 2017, yet 30 accident and incident reports were recorded for May 2017. We found no information to show that this threefold increase had been explored or evidence to show that themes and trends had been considered.

An infection control audit had been carried out on the first day of our inspection. The manager gave us a copy of this on our second day. Some items identified had no actions to show how any required improvement would be made. For example, the manager had identified that not all staff had received accredited infection control training, but there was nothing to show how or by when this would be addressed. This was also identified on the infection control audit dated January 2017. One person who used the service was identified as being a carrier of the Clostridium Difficile bacteria; however there was no comment as to whether this information had been shared with staff or how infection control practice was being used to ensure the safety of people and staff in the home.

This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.