Morleigh Limited

Clinton House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced focused inspection took place on 2 February 2016. The last inspection took place on 20 October 2015, and at that inspection the service was not meeting the requirements of the regulations. We issued requirements and a warning notice and told the provider to take action to address the breaches of the regulations. Following the inspection in October 2015 the provider sent the Care Quality Commission an action plan outlining how they would address the identified breaches. We carried out this inspection to check on the actions taken by the service to meet the requirements of the regulations.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clinton House on our website at www.cqc.org.uk

Clinton House is a care home which offers care and support for up to 46 predominantly older people. At the time of the inspection there were 30 people living at the service. Some of these people were living with dementia. The building is a detached house over two floors with a
recently added extension on the ground floor comprising of five new en suite rooms.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008.
and associated Regulations about how the service is run. The service did not have a registered manager in post. The manager who was previously applying to be the registered manager at our last inspection had been moved to another service in the group. However, there was a new manager in post at this inspection, who had now applied to become the registered manager. The new manager present at this inspection had been in post since November 2015.

At the last inspection we found medicines storage, recording and administration was not entirely safe. Care plans did not always provide staff with clear guidance on how to respond to risks and help reduce them. Accidents and incidents that took place in the service were not always recorded by staff in people's records. The safeguarding adults policy did not contain the contact details of the local authority or the Care Quality Commission to assist people in raising any concerns they may have.

At this inspection we found some improvements had been made to the recording and administration of medicines. There were no gaps in the Medicine Administration Records (MAR) or handwritten entries of the MAR. Medicines that required stricter controls were recorded accurately and the records balanced with the stocks held. The cold storage of medicines was being monitored daily and was within safe limits. However, creams were not always recorded when started and not always stored safely. A recent external pharmacy audit highlighted concerns which remained since the last audit which produced actions that needed to be taken a year before. Medicines for disposal were not stored in accordance with advice given in January 2016. Out of date blood bottles and needles were found.

Accidents and incidents were recorded by staff in people's records and these incidents were audited by the new manager. Care plans showed that where a risk had been identified there was guidance for staff on how to support people appropriately in order to minimize risk and keep people safe. The safeguarding adults policy had been reviewed and updated appropriately. However, we found hot water recorded at 50 degrees centigrade coming from a tap in a toilet used by people who lived at the service. Hot water at this temperature risks scalding people.

At the last inspection we found incontinence odours were present at the service. People's care records were not stored securely. Equipment was found lying in corridors such as TV's, parts of a bed rail, a mattress pump unnamed continence products and a broken call bell. This posed a risk to people using the corridors. Complaints made about the service were not always recorded and responded to in line with the complaint policy.

At this inspection we found some incontinence odours remained. This was mainly due to staff not disposing of bed pans and pads effectively. Unnamed continence products for communal use had been removed from bathrooms and toilets. Equipment left in corridors was reduced but some remained. Sharp scissors were found in a bag, in a corridor continuously used by a person living at the service who was confused. The premises and equipment used at the service was not reviewed effectively in order to identify any defects or faults. People's food and drink intake was recorded but not monitored. This meant action was not always taken to address any reduction in a person's intake. Guidance provided for staff about people's needs was not always accurate. A written complaint made to the new manager three weeks before this inspection had not been investigated, responded to or recorded in the complaints record.

At the last inspection we found that moving and handling slings and net pants, used by people to secure their continence products were unnamed and shared communally. At this inspection we found this practice had continued. In addition, we saw that people were being weighed openly in front of other people that used the service in a communal lounge. We also saw uncovered hot food given to a person and then left for 25 minutes before staff arrived to support the person with eating their meal. These examples of poor practice did not protect people's dignity.

At the last inspection we found people's care needs were not always met. People were not always re positioned according to the guidance in their care plans. At this inspection we found guidance in care plans was being followed by staff. However, some guidance was not clear. For example, one care plan stated 'turn regularly.' This did not provide specific directions to staff about how often to help each person to move to ensure people would not be at risk from pressure damage to their skin. Another care plan stated a person 'disliked baths' and then later in the same care plan it stated they liked baths twice a week.

At the last inspection we found people's confidential care records were not held securely at the service. At this inspection we found this concern remained. The service had fitted a lock to the door of the office where care plans were stored, however, this door was propped open throughout the inspection and was regularly unattended.

At the last inspection 'Taster' days were offered to potential new staff who had not done care work before to give them a clear idea of the role before applying. There were no processes or safeguards in place to ensure the people who did 'taster' days would respect people's right to privacy. This meant there was a potential risk of a breach of confidentiality when the person who had done the 'taster' day left the service. At this inspection people attending 'taster' days were required to sign a confidentiality agreement. People were strictly supervised and shadowed an experienced member of staff during their shift. During this inspection we saw a person was having a 'taster' day and they confirmed they had signed a code of confidentiality

document and were always under supervision.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe. Medicines were not always stored safely. Some actions set by an external pharmacy audit had not been addressed since 2015.

There were unidentified and unmanaged risks from very hot water from the facilities in the service.

Accidents and incidents that took place were being recorded in people's files and audited by the manager.

Is the service effective?

Requires Improvement

The service was not entirely effective. Equipment was not always stored safely and regularly checked to ensure it was safe to use.

Action was not always taken by staff when a person's food and fluid intake had reduced, and weight loss was recorded.

The service had updated their policy related to the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not entirely caring. Peoples' dignity was not always maintained because of some care practices used in the service..

Staff were kind, patient and provided care in a calm manner.

Is the service responsive?

Requires Improvement

The service was not entirely responsive. Information provided for staff in people's care plans was not always accurate.

Guidance in people's care plans was not always followed by care staff.

Nurses used both robust systems to ensure peoples' medical dressings were changed appropriately and involved external healthcare professionals as necessary to advise and support

people's wound care needs.

Is the service well-led?

Requires Improvement

The service was not entirely well led. People's confidential information was not stored securely.

Staff disciplinary processes were not recorded effectively.

The manager had started to audit a number of areas of the service. However these audits were not always identifying areas where action needed to be taken.

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

The inspection took place on 2 February 2016 The inspection was carried out by two inspectors and a specialist nurse advisor. The specialist advisor had a background in providing nursing care for older people and in the management of nursing care services.

Before the inspection we reviewed the information we held about the home. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with five people who lived at the service. Not everyone we met who was living at the service was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and also observed care practices.

We looked at care documentation for 10 people, medicines records for 30 people, five staff files, training records and other records relating to the management of the service.

We spoke with one visitor, five staff, the deputy manager, the nurse on duty, the clinical lead, the manager, the operational lead and the provider.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in October 2015 we found breaches of the regulations. We issued a requirement notice about the following issues. Medicines storage, recording and administration was not entirely safe. Records of handovers between shifts were not providing staff on each new shift with sufficient information to ensure they were clear on the care required for each person. Care plans did not always provide staff with clear guidance on how to respond to risks and to help reduce them. 'Taster' days were offered to potential new staff who had not done care work before to give them a clear idea of the role before applying. There were no processes or safeguards in place to ensure the people who did 'taster' days would respect people's right to privacy. This meant there was a potential risk of a breach of confidentiality when the person who had done the 'taster' day left the service. Accidents and incidents that took place in the service were not always recorded by staff in peoples' records. The safeguarding adults policy did not contain the contact details of the local authority or the Care Quality Commission. This meant staff would not be able to find the necessary information should they need to raise a concern outside of the service.

At the last inspection in October 2015 there were gaps in the Medicine Administration Records (MAR) where staff had not always signed to show people had received their prescribed medicines. Handwritten entries made by staff on to the MAR following advice from medical professionals, were not always signed and witnessed by two staff, to help ensure the risk of errors was reduced. Creams were not dated upon opening. This meant that there was a risk of potential errors and did not ensure people always received their medicines safely. The refrigerator used for the cold storage of medicines was not regularly monitored and was not consistently storing medicines between 2 and 8 degree centigrade. The service held medicines that required stricter controls by law. There was one item which had not been clearly recorded when it arrived at the service. Regular medicines audits were not consistently identifying when errors occurred. This meant people were not protected from the risks associated with unsafe medicines management.

At this focused inspection we found the provider had taken action to address some of these concerns with the medicines administration system. There were no gaps in the MAR. There were no handwritten entries on the MAR. Medicines that required stricter controls were recorded accurately and the records balanced with the stocks held. The cold storage of medicines was being monitored daily and was within safe limits. However, creams remained undated when opened. This meant staff were not aware of the date when the item would no longer be safe to use. Two tubs of prescribed creams were seen in a person's bathroom on top of a heater, which was turned on. The recommended temperature for the safe storage of this item was below 25 degrees centigrade. This meant the cream in the two tubs was not stored at the recommended temperature.

People were being given homely remedies by nurses, such as paracetamol without the GP having previously agreed it was safe for people to take them along with their prescribed medicines. This meant there was a potential risk of a negative interaction with other medicines already taken by the person. An external pharmacy audit in January 2015 had highlighted actions that were required by the service. A second external pharmacy audit in January 2016 repeated some of these actions as they had not been addressed by the service. Out of date medicines were found by the pharmacist at the service and a MAR sheet showed one

item did not match the directions on the medication package. This meant staff were not clear what dose to give to the person. The pharmacy audit stated; "The Morleigh group still need to review and update their medication policy despite correspondence and advice from the Medicines Optimisation Team going back several years. This issue had been raised on the 20th January 2015." The policy had not been updated at the time of this inspection. The pharmacy audit also stated that medicines for disposal should be clearly marked and kept in a tamper proof container within the medicine cupboard/trolley until collected. At this inspection a labelled open basket was seen in the medicine room containing medicines for disposal. They were not in a tamper proof container. This meant the service had not complied with the instructions on how to keep these medicines safe, as advised on 11 January 2016 and before that 20 January 2015.

At this inspection we found there were out of date blood sample bottles and needles held at the service. This meant effective stock checks were not being carried out.

This was a continued breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) 2014.

At the October 2015 inspection we found pre-printed handover sheets used by staff at shift change meetings were not always dated. This meant we could not establish which information was handed over on what day. Some staff had updated some people's handover records by hand during the shift to inform the new shift of any changes. Other handover sheets were only ticked rather than containing meaningful information for staff. We identified some confusion amongst the staff about what care some people required.

At this inspection the service was unable to provide handover sheets for shift changes that had taken place since 25 January 2016. Before 25 January 2016 the handover sheets contained ticks with occasional written amendments on some sheets to guide the new shift. There were also handover sheets which were undated. This meant it continued to remain difficult to establish what information had been provided for staff at each shift change.

A toilet, used by people living at the service, was found to have hot water which was recorded by the inspector in the presence of the manager at 50 degrees centigrade from the sink tap. This was a scald risk to people using the sink when washing their hands. The care management of the service was not aware of this risk. There was a small sign stuck to the wall above the sink stating "Caution hot water". When we made the management of the service aware of this issue, the service decided to close the toilet immediately.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the October 2015 inspection, risks had been identified and assessed in people's care plans. However, the care plans did not always provide staff with clear guidance on how to respond to those risks and help ensure they were reduced.

At this focused inspection care plans contained risk assessments for a range of circumstances including pressure damage risk and the likelihood of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimize risk and keep people safe. For example there was information for staff about how they might distract a person who could become anxious, with a cup of tea or a chat. One person had been assessed as having a poor sleep pattern. This had been treated with medication and the review had found an improvement in this person's sleep pattern. The medication had been reduced to ensure the person remained settled without receiving too much medication. This meant risks were being monitored and reviewed.

At the October 2015 inspection people applying to work at the service, who had not done the work previously, were invited to have a 'taster' day at the service. This involved working alongside experienced staff, before formally applying for a post as a care worker. The people who attended 'taster' days had access to all areas of the service and could work with all the people living there, as well as having access to care files containing people's personal private information. Some people who had experienced 'taster' days had chosen not to take the position. However, there were no processes or safeguards in place to ensure the people who did these 'taster' days would respect people's right to privacy. This meant there was a potential risk of a breach of confidentiality when the person who had done the 'taster' day left the service.

At this inspection people attending 'taster' days were required to sign a confidentiality agreement. People were strictly supervised and shadowed an experienced member of staff during their shift. During this inspection we saw a person was having a 'taster' day and they confirmed they had signed a code of confidentiality document and were always under supervision. Throughout this inspection the person was seen alongside an experienced member of staff and closely supervised. One staff member told us they felt the 'taster' days were, "A great idea, especially to get a feel for the place and meet the team."

At the October 2015 inspection accidents and incidents that took place in the service were not always recorded by staff in people's records.

At this inspection accidents and incidents were seen recorded in people's records and audited regularly by the acting manager. The service was using a process to carry out an audit of peoples' falls. This provided staff with guidance to follow to try to reduce the risk of further falls, if a person fell more than three times in a month.

At the October 2015 inspection the safeguarding policy did not contain any contact details for the local authority or the Care Quality Commission. This meant staff would not find the information they required should they need to raise a concern outside of the service.

At this inspection the safeguarding policy had been reviewed and contained the necessary contact information to guide staff and people about where to report any concerns they might have.

Staff told us they felt staffing levels were sufficient to meet people's needs. We checked the rota and found six staff worked in the mornings, with five in the afternoons supported by a nurse. The manager told us the service was fully staffed at the time of this inspection.

This meant the provider had taken action to address some of the concerns raised at the October 2015 inspection.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in October 2015 we found there were incontinence odours throughout the service during the inspection. Full yellow bags holding used continence pads were found in corridors and in sluices and had not been correctly disposed of. The towels and flannels used by staff to wash people, were very old, frayed and faded. There were few signs or other types of support for people who were living with dementia and needed help to orientate to their surroundings. Bathrooms and toilets were not clearly marked with pictures and bedroom doors held only nameplates and numbers. There were many items lying on the floor in corridors, such as a handling belt, a television, part of a bed rail, a mattress pump, unnamed unused continence pads, a broken call bell, and foam support wedges. We asked the deputy manager who they belonged to on each occasion and they did not know. There was a broken washing machine, two hoovers and a wheelchair stored in the corridor outside the laundry. We were told by the provider these were awaiting disposal. A new washing machine had recently been delivered. Equipment was not stored appropriately, some equipment used was not suitable for purpose and hygiene issues were not adequate. The service had not updated their Deprivation of Liberty Safeguards policy to reflect the change in the legislation.

At this inspection we found incontinence odours remained in some areas of the service. This was due to staff not disposing of used bed pans and pads efficiently. There was less unused equipment and items left in corridors, however, some items remained. There was a named walking frame in a corridor for a person whose room was elsewhere in the building and who was now continuously cared for in bed. This was together with a mattress pump, an unnamed pressure relieving cushion and a metal bar, all left on a ledge in a corridor. In another corridor there was a commode without a bowl, with four unnamed pressure relieving cushions and an unnamed slide sheet. In a third corridor area of the service we found a pair of sharp scissors in a bag on a radiator cover. This corridor was used continuously by a person living at the service who was confused and mobile. These items posed a potential risk to people.

The old faded and frayed flannels seen at the last inspection had been replaced by new flannels which had been purchased by the service. However, the new flannels remained unnamed and were shared communally. A foot pedal on a clinical waste bin was not working. This meant staff had to use their hands to open the bin. Both issues created infection control risks.

A light was not working in a corridor used by people living at the service. This area was dark all day throughout the inspection. At the end of the day we asked the maintenance person if they were aware of this fault. They were not aware and it had not been reported by either the deputy manager, manager or staff working in the service that day. There were incontinence odours throughout the service experienced by all three inspectors the inspection. Staff had not disposed of faeces appropriately in a sluice, this was extremely malodorous for some time during the inspection. The sluice was next to a person's bedroom. Odours were also experienced in people's bedrooms and in communal areas. However, the level of malodour had improved since the last inspection.

We reviewed the checks made on the pressure relieving mattresses being used by people living at the

service. One person's mattress had a sticker stating it had been checked on 24 April 2015 and was due a review on 12 July 2015, a red power fail light was showing next to a green light. This showed that the mattress needed to be reviewed urgently. Another pressure relieving mattress had a motor unit with a next check date of 10 October 2014. A bath hoist supplied in May 2013 had a sticker stating a test was due in May 2014. A control knob was missing from the motor of a further mattress. The stickers on this equipment did not indicate that regular tests had taken place. This meant staff could not be assured the equipment was safe to use.

These issues had not been identified through the services audits or been addressed.

This is a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Food and drink intake monitoring charts were being kept for 16 people at the service. Information recorded on these charts was not being monitored. Minimum and maximum amounts of food and fluids received were recorded on the charts to guide staff what had been assessed as an appropriate intake for each person to have in a day. However, information on these charts was not always accurate as sheets were being photocopied and specific information relating to other people's assessments and reviews remained on the photocopies used for different people. Totals of food and fluids received were not recorded at the end of each day and there was no record of people's intake being monitored regularly. A review of a person's food and fluid chart had taken place on 18 January 2016 and another on 28 January 2016. However, this information had been repeatedly copied on to other people's charts. This meant the staff were not provided with accurate information relating to each person who was having their intake monitored. Several people's intake had been recorded at below their assessed minimum required amount. Staff had not taken action when a person's intake fell below what had been assessed as minimum amounts for each individual. For example, four people had charts which stated the minimum amount they should eat was half of their meals. It had been recorded that between the 30 January and 1 February there were six occasions when these four people ate a quarter of their meals. These records were not monitored regularly therefore no action had been taken. This meant people were at risk of potential weight loss and dehydration.

One person's care file stated; "Staff to monitor fluid intake" and that the person's "kidneys cannot cope with more than 3 litres a day, restricted to 3 litres in 24 hours" The care plan and staff confirmed this person would repeatedly ask for drinks throughout the day. This person was not having their drinks intake monitored at the time of this inspection.

Another person was having their weight recorded and had lost weight. The service had requested advice from an external healthcare professional to support them with the care of this person.The care plan stated they were required to have two high calorie drinks each day. Records showed none had been given on 31 January and 1 February 2016 and one given on previous dates. Another person's care plan stated, "Encourage 1.5 to 2 litres of fluid." However, this was not recorded as guidance for staff on the person's food and fluid record and was not being monitored to ensure the person had sufficient fluids each day. This meant staff were not following the guidance provided in people's care plans and identified nutritional risks were not being managed effectively.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

While we had no specific concerns about supervision of staff at the last inspection the clinical lead reported at a meeting the day before this inspection that all staff had had individual supervision session. At this

inspection we found two nurses and two care staff who had no recorded individual supervision sessions recorded on the matrix given to us by the manager and which had begun in October 2015. Staff confirmed, "It (supervision) was ages ago, over 12 months" and "It is not taking place." However, staff told us they generally received good training and support. They told us, "Love working here" and "We are a good team." The training matrix we were given by the manager showed staff were provided with appropriate training and updates as needed. However there was no training provided for staff about managing the behaviour of people that challenged the service. Staff told us they did experience aggressive and other behaviours from some people living at the service that challenged them and they did not feel skilled to work with.

Six staff had been enrolled on to the Care Certificate. The Care Certificate replaced the Common Induction Standards in April 2015. It is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector.

The service had removed the broken washing machines and hoovers from the laundry area and taken some action to improve the signage around the service. This helped people who required guidance and support with recognising where they were. Bathrooms and toilets had clearer signage at this inspection. However, one person who was living with dementia and walked around the service throughout the inspection, had moved bedroom in December 2015. However, the name plate on their present bedroom door was blank and there was no other signage or pictures at their room to show them this room was theirs. This made is more difficult for them to identify their bedroom. There was not sufficient signage throughout the service to support people who needed additional help with recognising their surroundings.

At the previous inspection unnamed continence products were present in a number of bathrooms and toilets indicating that they were being used communally rather that only for the person they were prescribed for. At this inspection there were no unnamed continence products in bathrooms and toilets for communal use.

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 to 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). At the previous inspection we found the service had not updated their DoLS policy to reflect changes in this legislation. At this inspection the service had updated their policy on Deprivation of Liberty Safeguards to reflect the changes in the legislation. This meant staff were provided with accurate and current guidance.

Requires Improvement

Is the service caring?

Our findings

At the October 2015 inspection there were numerous communally used moving and handling slings and belts, hanging in corridors, used by staff to support people. Some people had been assessed as requiring specially obtained close fitting net pants to help secure their specific continence pads. We saw these pants were shared communally and were not named for each person's individual use. Sharing equipment and underwear does not respect people's dignity. Continence pads were specifically assessed for each person. However we saw many packs of continence pads in bathrooms and corridors which were unnamed and used communally. This meant it could not be ensured that people always had access to their specifically assessed pads as these were being shared throughout the service.

Also at the October 2015 inspection toilet doors did not have any locks on them. This meant people could not ensure their privacy and dignity when using the toilets. Throughout the inspection visit all bedroom doors were held open and each person was clearly visible from the corridors. We did not see any documentation in people's care plans which showed they had been asked if they wished to have their doors open at
all times.

At this inspection moving and handling slings remained unnamed and were being used communally. They were hung out in main corridors throughout the service. Net pants used to secure continence pads remained unnamed, and were shared communally throughout the service. People were regularly weighed on a hoist scales in the main lounge in front of other people. We asked staff about where people were weighed. They told us; "Always done in the lounge." These practices showed the service did not give people dignity and privacy.

The external healthcare professional we spoke with also raised concerns about hot food on trays arriving uncovered well before mealtimes so food was getting cold before people were able to eat it. At this inspection a hot meal was seen delivered uncovered to the room of a person lying on their back in bed at 12.50pm. Staff did not arrive to provide support for this person to eat their meal until 1.15pm. When we questioned staff about the now cold meal, they offered the person a sandwich instead, which was provided. These practices showed the service did not consider people's dignity.

Some people's bedroom doors were closed throughout the inspection. This meant some people were provided with privacy.There were no records in people's care files of them having been asked if they wished to have their door open or closed. Some people's doors remained open throughout the inspection. People's bedroom doors were marked with people's formal names, however, one person who had moved rooms at Christmas to a ground floor room did not have their name on their door. This person was confused and living with dementia and not having their bedroom clearly identified for them did not support their needs.

All the practices above did not respect people's dignity and human rights and represented institutional practice.

This is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have told the provider to take at the end of this report.

Before this inspection external healthcare professionals had raised concerns about a person who had identified weight loss and who was not supported to eat at mealtimes. This person was supported to eat their meal at this inspection and was having their food and fluid intake recorded.

Toilet doors now had locks fitted and clearer signage on toilets and bathrooms had been added. This meant people were more easily able to access these facilities independently more easily and had privacy while they was using them.

During the inspection staff interacted with people in a patient, calm and supportive manner. We heard staff chatting and laughing together with people in the lounge, dining area and their own bedrooms. However, staff told us they were, "Not allowed" to sit and chat with people living at the service. They told us, "We get into trouble" if they are seen sitting down. A visitor told us they had no concerns about the care provided for their family member, who they felt was well looked after.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in October 2015 we found guidance from assessments recorded in care files was not always followed by care staff. One person should have been re positioned two hourly according to their care plan. Staff were not clear about what care was required and re positioning was recorded once or twice in 24 hours. This person had sustained skin damage found by the inspector at the inspection, which had not been recorded and acted upon. Another person's file stated "monitor skin 2 x daily." There were no records to show this had been done. Staff told us a specific cream was being used for a person. It was not present in their room and upon asking the nurse it was confirmed that it was not in the service. We were also advised that external healthcare professionals had reported concerns of the poor care of two other people living at the service, to the local authority.

An external healthcare professional visiting the service the week before this inspection, had found a person both in a very wet bed and a soiled continence pad at 3pm. The last record of care provided was 10.10am. They were lying on a mattress with an incompatible pump which meant the effective performance of this pressure relieving mattress could not be assured. The manager immediately hired a new mattress for this person. This person did not have any skin damage at the time of the inspection. Following the inspection we received further allegations of poor care provided by night staff. These concerns were raised by a whistleblower and were reported to the local authority.

At this inspection we did not see any evidence of people lying in wet beds. There were no new pressure areas being treated by the nurses at the service at the time of this inspection. The tissue viability nurse reported that no new skin damage had been reported recently. Skin bundles are records used to record the whole body checks which are made by staff during personal care. These charts were being used inappropriately by staff to record the re positioning of people. This meant the records were difficult to review as there was not enough space on the chart to record the re positioning clearly.

One person's care plan stated; "Weigh monthly." In November 2015 a weight of 55.5kgs was recorded. No weight was recorded in December 2015. In January a weight of 54 Kgs was recorded. This meant the person had experienced a loss of 1.5kgs. The care plan stated; "Any concerns about weight loss refer to SALT." SALT is the speech and language team who assess and then advise on how people can improve their nutrition. The manager confirmed this had not been done. When a person had identified weight loss the service was not acting to stop this weight loss and ensure the person gained weight.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The manager confirmed at a meeting the day before the inspection, that all but four people's care plans had been completely re written to make them more person centred. We were assured by the manager that the four remaining care plans were correct with sufficient information to keep people safe. However, when we inspected the service we found that some care plans contained some inaccurate information. For example, one person was cared for in bed and required two staff to move them in the bed during this inspection. Their care plan stated they were; "Independent and able to move." Another person's care plan stated skin

bundles were to be done four hourly day and night and an air filled boot to be used to relieve pressure on their skin at night. This person told us this boot was not always being used at night and there were no records in their care file to show this care was being provided as directed in the care file. This person did not have any skin damage identified at this inspection.

One person's care plan clearly stated they required; "10 minute observations." The manager and clinical lead confirmed this was out of date information and they no longer needed this level of monitoring. Another care plan stated the person 'dislikes baths' yet further on in the same care plan it said the person liked twice weekly baths. 'Regular turns' was stated in one person's care plan with no frequency specified for staff. This person was being provided with end of life care and was confined to bed.

One person's care file stated; "This person has been upped to two supplements a day." This information was recorded on their food and fluid intake chart but was not being carried out by staff. The care plan stated; "Weigh monthly." The weight records for this person stated; October 2015 35.5 kgs, November 2015 39.8 kgs, December 36.6 kgs, 18 January 2016 32.1 kgs, 25 January 2016 33.1 kgs, 1 February 2016 32.8kgs. The records related to this person's weight were not held in a clear format, as they were recorded on separate sheets. The weights were reported as 'unreliable' by external healthcare professionals because they were concerned about the accuracy of the weighing scales being used in the service. People were not being weighed as directed by their care plan and the accuracy of the records was unclear.

Staff were experiencing behaviour from people which challenged them and staff had been injured by people living at the service. However, there was no guidance or information for staff on how to respond when such behaviour occurred. Such incidents of these behaviours were recorded by staff on charts in one person's room however, there was no evidence of review or monitoring of these continuing incidents by the manager.

People's care plans and care records had been reviewed regularly but did not either always accurately reflect people's current needs, or that action had been takene to address peoples' changing needs.

This contributed to a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

There were some signatures from people's relatives in care plans, where they had been given the opportunity to agree to the care planned for their family member.

At the last inspection there were concerns about the system used by the nurses to record when they changed people's dressings. Records were not being kept in a consistent manner at that time. This meant it was difficult to establish when dressings had been changed. At this inspection we found there was a clear system in place to record each person's dressing change and when it was due for the next change. External healthcare professionals were 'referred to' for support on skin tissue viability issues by nurses in the service and for advice on these people's ongoing care needs.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in October 2015 we found a cupboard in the main corridor marked 'keep locked'. This door was unlocked, and there were more than 60 records held in this cupboard, including confidential personal care records relating to people who lived at the service, and some archived records of people currently living at the service. This information was easily accessible by anyone using the corridor. The office where people's care records were held and used by staff was open throughout the inspection. The door was not lockable when staff left the room. This meant people's private personal information was not held securely and could be accessed by anyone.

Before the October 2015 inspection CQC had been contacted by the family of a person living at the service who had made a complaint to the provider about an incident that had taken place involving their family member. This complaint had not been resolved by the provider to the satisfaction of the family. This complaint had not been recorded in the complaints record held at the service.

The provider sent an action plan to the CQC following the October 2015 inspection, it stated; "Care records amended to reflect the individual needs of the service user to ensure that they direct staff accurately and records/charts are kept in an accurate manner to reflect care given." This was not found to always be the case at this inspection.

The new manager had been in post since November 2015. This inspection found some concerns from the last inspection had been addressed. However, there were some that remained and where no action had been taken by the provider. Although the new manager had made some improvements in some areas and was auditing a number of aspects of the service provision these audits were not always effective in identifying the concerns found at this inspection. For example, the faults in; care plans for some people living at the service, the monitoring and storage of records, management of equipment, the premises, and complaints management.

The service user guide contained out of date information. For example, the guide stated CQC do two inspections each year, one announced and one not. This was incorrect and has not been the case for some years. The contact details for the local authority were also incorrect. This meant the information provided to people and their families was not accurate and up to date.

The cupboard in the corridor containing over 60 records relating to people's care remained unlocked as before. The office where people's care records were stored remained open throughout the inspection when unattended by staff. The provider had fitted a coded lock to this door, however it was propped open throughout this inspection and was regularly unattended. This meant people's confidential information remained insecurely stored.

The manager stated at a meeting the day before this inspection that two staff had been subject to a disciplinary process for failing to provide care and complete documentation, for the person found by the tissue viability nurse some days before this inspection. We checked these staff members' files. There was no

record of disciplinary action being taken against either member of staff. We were told by the manager one of the staff had resigned immediately and left the service and the other member of staff had 'been spoken to.' This meant there was no formally recorded action taken to address the concerns raised by an external professional about the care provided at the service.

The manager also stated that hourly checks were being carried out by the manager and their deputy throughout their shifts. We were told these checks included that pad changes had been made and the accurate recording of care by staff. At this inspection we were not able to evidence this and there were no records of such checks taking place. The manager and the clinical lead told inspectors at the start of the inspection there were three people living at the service who were having their food and fluid intake monitored. We found there were 16 people having their food and fluid intake monitored. This meant the manager and the clinical lead did not have good knowledge of people's needs or how they were being cared for.

Handover sheets, used by staff to communicate people's care needs and any outstanding actions, were not available to inspectors after the 25 January 2016. We were told senior care staff carried out checks twice a shift on carers' notes, food and fluid intake charts and topical medicine charts. There was only one of these check sheets available at this inspection dated 16 January 2016. The manager could not find any further records.

At this inspection we found a member of staff had raised a formal written complaint about the delivery of poor care to the manager three weeks before this inspection. The allegation was that three people who lived at the service were repeatedly found in wet beds in the mornings, having not had care provided for some time by named night staff. The staff who had raised the complaint had not received any response following an investigation in to their concern. The complaint had not been recorded in the complaints record. The manager was unable to provide us with a copy of this complaint. The provider was unaware of this complaint having been raised. Staff told us they felt, "Nothing would get done" and told us people's continence care needs were not always met at night.

The complaints policy had been reviewed in December 2015 and stated that complaints should be acknowledged within five working days and investigated within 14 days. This meant the service was not following its own policy.

Three days after the inspection we received anonymous information from a whistleblower that people were not having their needs met at night and that people were not having their continence pads changed for long periods during the daytome.

This is a continued breach of Reg 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The new manager had been in post since November 2015 and had made some improvements in some areas. The manager was auditing a number of aspects of the service provision. However, these were not always effective in identifying the concerns found at this inspection. You can see the action we have told the provider to take at the end of this report.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users must meet their needs. (1) (b) (3) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment All premises and equipment used by the service provider must be appropriately located for the purpose for which they are being used, and properly maintained. Regulation 15 (1) (e) (f)

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Service users must be treated with dignity and respect. Regulation 10 (1)

The enforcement action we took:

warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person must assess the risks to the health and safety of service users and do all that is reasonably practicable to mitigate any such risks. The proper and safe management of medicines could not always be assured. Regulation 12 (a) (b) (g)

The enforcement action we took:

warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes must be established and operated effectively, and enable to registered person to maintain securely such other records as are necessary to be kept in relation to the management of the regulated activity. The registered person should act on feedback from relevant persons on the services provided in the carrying on of the regulated activity, for the purposes of continually improving the service. Regulation 17 (2) (b) (e)

The enforcement action we took:

warning notice issued