Care Quality Commission

Key inspection report

CARE HOMES FOR OLDER PEOPLE

Euroclydon Nursing Home

Drybrook
Gloucester
GL17 9BW

Lead Inspector
Mrs Janice Patrick

Key Unannounced Inspection
11th June 2009 09:55

This report is a review of the quality of outcomes that people experience in this care home. We believe high quality care should:

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care homes for older people can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop.

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

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SERVICE INFORMATION

Name of service	Euroclydon Nursing Home
Address	Drybrook Gloucester GL17 9BW
Telephone number	01594 543982
Fax number	01594 544352
Email address	
Provider Web address	
Name of registered provider(s)/company (if applicable)	Chantry Retirement Homes Ltd
Name of registered manager (if applicable)	Mr Stephen John William Evans
Type of registration	Care Home
No. of places registered (if applicable)	48
Category(ies) of registration, with number of places	Old age, not falling within any other category (48)

SERVICE INFORMATION

Conditions of registration:

1. To accommodate 5 (five) named service users under the age of 65 years - Service User Category PD.

   The home will revert to the original service user category when these service users no longer reside at the home or reach the age of 65 years.
2. To accommodate 1 (one) service user under 65yrs of age on respite care. This bed to be used for respite care only of a period no longer than 1 month unless prior agreement with CSCI. Not to be used for a permanent resident under 65yrs of age.

Date of last inspection 22nd July 2008

Brief Description of the Service:

This registered care home predominantly cares for people over the age of 65 years, although there are a few people who are younger and who have a physical disability.

The home provides thirty-eight single and five double rooms. Twenty-eight rooms offer en suite facilities. In addition, there are a number of assisted bathrooms and toilets on each floor. There are several communal areas and a separate smoking room. Access to the first floors is by passenger lift.
The gardens are well maintained and accessible to all residents and include a summerhouse.
There is a long drive to the property but in front of the house is ample car parking. The home has its own tail-lift mini-bus.
Public transport to and from the home is limited and buses only go as far as the local village of Drybrook, which is half a mile away. In certain situations and through prior arrangement, the home will provide a lift from the village.

The fee range is determined on an individual basis and does not include hairdressing, chiropody (foot care) and newspapers.
The home provides funded respite care.

Information on the services provided along with the last inspection report, can be obtained from the home on request.

SUMMARY

This is an overview of what the inspector found during the inspection.

The quality rating for this service is 0 star. This means the people who use this service experience poor quality outcomes.

The judgements contained in this report have been made from evidence gathered during the inspection, which included a visit to the service and takes into account the views and experiences of people using the service.

Two inspectors carried out this unannounced inspection over three days. As part of this key inspection one of our (the Care Quality Commission) pharmacist inspectors examined some of the arrangements for the handling of medicines. We looked at some stocks and storage arrangements for medicines and various records about medication. We saw how staff administered some medicines in various areas of the home and we went to some bedrooms. In relation to medication we spoke to the manager, deputy manager, two registered nurses and a carer. We gave full feedback following the inspection to the manager about the medication issues we found. This part of the inspection took place for eight and a half hours on a Thursday (the first day of the inspection).
Additional areas of inspection included those where there had been past concerns and where requirements had been made in order to secure compliance with the Care Home Regulations 2001.
Questionnaires were not sent to service users (residents) or relatives on this occasion.
The home forwarded their Annual Quality Assurance Assessment report and some information from this has been included in the report.
We have also considered all other information collected by us since the last main Key Inspection in July 2008.

What the service does well:

Where ever possible the home carries out a pre admission assessment prior to someone's admission. This nearly always will include information on the person's needs sent by the local funding authority if the person's care needs are to be funded.
The medicines needed by people living in the home were available for staff to administer.
The kitchen staff give a very good service and provide meals that meet people's personal preferences and dietary needs.
When activities are provided, they are enjoyed by the people taking part and there is a real aim to provide entertainment that people would enjoy.
Some people's specific preferences are met well.
The home provides plenty of modern and spacious bathroom facilities.
Qualified nurses liaise with a number of external healthcare professionals as required to help meet people's specific needs.
People's personal monies and accounts are managed in an organised and transparent manner.

What has improved since the last inspection?

People who are nutritionally at risk are now being monitored well to ensure they receive all the support they require.
The home's Annual Quality Assurance Assessment tells us of many initiatives that have been introduced to help improve the service provided. These include a better provision of activities and improved arrangements to involve residents and relatives in care planning and decision making.
Training of staff is an ongoing improvement and the home is actively using external healthcare professionals to respond to staff training needs.
Recruitment practices have improved, helping to protect people from harm and abuse.

What they could do better:

The report highlights a number of improvements that are needed in the management of medicines.
It also identifies a number of inconsistencies in the assessing of people's needs after admission.
These shortfalls have had a direct impact on the planning of people's care, which is not always relevant or comprehensive in content. This requires urgent improvement as it leads to poor guidance for staff in how needs are to be met.
The current arrangements for the management of specific risks are not robust enough, leaving people still open to potential harm.
People's abilities and needs are not consistently assessed in respect to safe moving and handling and this is leading to confusing information for staff.
Adverse events and people's serious injuries are not being appropriately reported to us or other agencies.
There is a lack of robust protocol that says anyone who has a fall and sustains an injury or produces evidence of a possible injury is seen by a medical practitioner to eliminate the need for further medical attention or pain relief.
Staff have lacked the skills in recognising a pressure sore and treating it. This needs addressing by additional training and robust auditing.
General organisation and communication within the home is poor and at times this has a negative impact on those living there. This must be improved and day to day leadership demonstrated by improving the areas that have failed in this inspection.
The management of complaints does not always result in appropriate action being taken. This needs addressing and the action 'as stated' must be carried out.
The extension area of the care home must be tidied up and kept clean so as to prevent unnecessary accidents and improve the overall presentation of the home.
People must be provided with furniture that meets their needs and which is always fit for purpose.
There must be enough qualified staff on duty to meet people's needs and maintain good record keeping.

The management team need to examine how they communicate with staff and reassure themselves that how this is done is effective and constructive.
Staff supervision should always be recorded.
Specific discussions with staff following incidents that have had a negative impact on people living in the home must always be recorded.
Improve the filing of staff training certificates and keep training records up to date so that training that has been completed can be easily identified.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk. You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line – 0870 240 7535.

DETAILS OF INSPECTOR FINDINGS

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Choice of Home

The intended outcomes for Standards 1 – 6 are:

1. Prospective service users have the information they need to make an informed choice about where to live.
2. Each service user has a written contract/ statement of terms and conditions with the home.
3. No service user moves into the home without having had his/her needs assessed and been assured that these will be met.
4. Service users and their representatives know that the home they enter will meet their needs.
5. Prospective service users and their relatives and friends have an opportunity to visit and assess the quality, facilities and suitability of the home.
6. Service users assessed and referred solely for intermediate care are helped to maximise their independence and return home.

The Commission considers Standards 3 and 6 the key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

2 & 3
People using the service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

There are arrangements in place to ensure people are made fully aware of their contractual and financial responsibilities.
Although the process of assessing someone's needs is being carried out prior to their admission, how this information is then being used and how people's needs are being communicated to the staff team is compromising the service's ability to then fully ensure that people's needs can be met.

EVIDENCE:

This outcome has been assessed using the Key Lines of Regulatory Assessment (KLORA) as guidance.
This service has a high turnover of service users (residents) predominantly due to arrangements with the local authority to provide short-term care, otherwise known as respite care. The home's Annual Quality Assurance Assessment (AQAA) tells us that 104

placements for either respite care or on an emergency basis have been made in 2008/09. Families are often keen that their relatives remain fairly local to where they live and therefore this service, being provided by a local care home is valuable to the local community. The AQAA says that many people return for additional respite care.
This maybe so but during this inspection the care home's ability to demonstrate that it can ensure people's needs are fully met following a pre admission assessment could not be evidenced in several cases.

It is important that any care home has a robust pre admission assessment process so that they are aware of an individual's needs and can make an informed decision about whether they can meet these or not.
It is probably even more important in this care home, because of the large turnover of people and needs, that the system for identifying needs and then planning how to meet them is effective and organised.
We can see from assessments that where possible, this service will visit the prospective resident and carry out a pre admission assessment. We can see that this includes additional information supplied by the family and involved healthcare professional/s. The home is nearly always in receipt of the 'assessment of needs' which is carried out by the local authority in cases where the person's care is to be funded.
We know that the care home will accept emergency admissions and it is not always possible for a member of staff to physically carry out a home's assessment before admission. In a situation like this the care home must still be able to make a judgement; based on the information it receives, as to whether it can meet an individual's needs before agreeing to an admission.
In both cases, be it respite care or an emergency admission the welfare of the existing resident group needs to be considered, including the limitations of the staff group.

We looked at the pre admission assessments of four people who were receiving respite care; all were receiving funding towards this care.
The first had been an emergency admission and initial information had been taken by staff in the home from the Social Worker over the telephone. However, later in the day the funding authority forwarded their assessment of needs to the home.
The second person's admission was planned so a pre admission assessment had been carried out and recorded by the care home manager, two weeks before admission. Again the local authority supplied an assessment of needs.
The third and fourth's person's admission was also planned and again the service had completed a pre admission assessment and an assessment of needs had been received from the local authority.
In all cases, the local authority's assessment outlined the person's basic needs and the authority's minimum expectation of how these needs were to be met.

We also looked at the pre admission assessment for one person who was admitted for permanent care. This person's needs were more complex and were also being funded so an assessment of needs from the funding authority was on file.

In each case we cross referenced the information given to the care home by the funding authority with that collected by the care home in its pre admission assessment. We then cross referenced the pre admission assessment information with assessments that are carried out by the home, following admission. The latter assessments are designed to identify the person's needs more thoroughly and identify any potential risks that may need

addressing. This information helps the qualified staff to devise care plans which then give guidance to the staff team on how someone's needs will be met. If possible it is good practice to involve the resident in this because they may have specific preferences in how their care is to be delivered (see next outcome).
It is how this pre admission information is currently being used and communicated that compromises the care homes ability to adequately ensure that people's needs are met.

The shortfalls are demonstrated in the set of examples below.
One person's basics needs had been identified by the local authority in their assessment of needs. This was an emergency admission so a pre admission assessment was not carried out by the home. When the home completed their usual post admission assessments, two areas of this person's care were not acknowledged and remained unaccounted for throughout the assessment process. During this inspection it was clear that there were existing needs that had not been assessed and planned for fully. One was very obvious as there was a very strong smell of urine in the bedroom. When we asked the member of staff who had completed the post admission assessments and care plans, what was being done about meeting these needs, they acknowledged that the local authority's assessment had identified continence problems but were unable to explain how this was currently being attended to.
The other area of need was also discussed and the staff member was equally unclear how this was being managed by the care staff and why the assessments and care plans had not really addressed the issues. This was despite the care home needing to request a visit by the local doctor less than 24 hours after the resident's admission because of a situation that arose and which required medication. It was recognised at the time that the occurrence was linked to the original problem, which had still not been care planned for properly. There were also further inconsistencies between the information in the assessment of needs and the care homes various assessments. These related to areas of risk such as this person's level of mobility and their current appetite.

In another case, specific preferences identified in the home's own pre admission assessment had not been transcribed into documentation completed after admission (see next outcome on care planning). This preference was about how the person wanted to be bathed, whether they preferred a shower or bath. Within the home's social assessment both these options were underlined, the same lack of clarity was found in the care file for the person spoken of above. The home's lack of ability to make it clear to staff, which form of bathing a person prefers has been identified in past inspections and was also one of the points raised in a complaint, made by a family about their relative's respite care (see Complaint outcome). In the care home's response to this complaint it had been decided that this preference would be identified within the admission process. For one person this had been done within the pre admission assessment but, subsequently for both the preference was not then recorded in the homes 'social assessment'. This then makes a difference to what is included in the care plan which is the document that gives staff their guidance.
When we asked both these people, which form of bathing they preferred, both were able to clearly tell us.
We noted in another person's care plan an entry that said 'needs help to have a bath, does not like showers'. At 6.45pm on the first day of this inspection a carer said to this resident that she will come along tonight and give her a shower.

In another case the person's assessments which identify risks such as their capability to walk and move around safely, their level of risk nutritionally and their susceptibility to pressure sores were being completed on the last day of this inspection, after the person had already been in the home for four days.

In another case there were discrepancies between assessments relating to personal care. Whilst talking to staff about people's needs one person told us that they had been unaware of someone's admission and had found out purely by accident and another knew someone had been admitted but knew little about them. These are key members of staff who should have overall knowledge of people's admissions and care.

In summary, we can see that the actual pre admission assessment format has improved over time and that people are being assessed prior to admission.
However, some of this information is then either just not being incorporated into the more detailed assessments that are carried out, after admission or it is being misinterpreted, which results in further assessments not being completed correctly. In some situations this seemed to be down to the individual nurse's lack of ability to complete assessments correctly, in some cases they were just not transcribing the information correctly, in one case there was an inability to express the written word in English sufficiently, which had already been identified by the Registered Manager as a problem specific to that person. Altogether communication between staff, both verbally and in the written form appears to be poor.

The home is certainly admitting people with very diverse needs and it is obvious that the staff team find it difficult to keep up with the ever changing needs of the resident group; a point we raised in January 2008 about the provision of respite care in this care home. The home's Annual Quality Assurance Assessment says that the aim is to provide 'person centred care'. The examples we saw in this inspection lead us to believe that the home is concentrating on 'filling beds' by providing a much needed service in the local area without concentrating and ensuring that each person receives a good standard of individualised care.
We inspected a selection of contracts for both private fee paying people and for those that are funded. Funded people are also provided with the care home's terms and conditions. Those that receive a contribution for their nursing care receive an invoice clearly stating the amount that has been deducted from the main fees and for what period of time this is for.

Health and Personal Care

The intended outcomes for Standards 7 – 11 are:

7. The service user's health, personal and social care needs are set out in an individual plan of care.
8. Service users' health care needs are fully met.
9. Service users, where appropriate, are responsible for their own medication, and are protected by the home's policies and procedures for dealing with medicines.
10. Service users feel they are treated with respect and their right to privacy is upheld.
11. Service users are assured that at the time of their death, staff will treat them and their family with care, sensitivity and respect.

The Commission considers Standards 7, 8, 9 and 10 the key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

7, 8, 9, 10 & 11
People using the service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Some people's needs are not being adequately thought through and subsequently planned; this means that there is poor direction for care staff, resulting in some people not having their needs adequately met. In some situations, a combination of this and poor practices are actually putting people at risk and no action is being taken to reduce these risks.

There are some suitable arrangements in place for the management of medicines but the inspection highlighted a number of particular weaknesses where improvements in these arrangements are needed so as to always protect people living in the home from unnecessary risks with medication.

EVIDENCE:

This outcome has been assessed using the Key Lines of Regulatory Assessment (KLORA) as guidance.

The qualified nurses are aware that people's needs must be clearly identified and that a plan of how their needs are to be met must be devised. We know this from past conversations we have had with staff and through past requirements having been made by us for this to be achieved.
These care plans are designed to: provide a record/audit trail of the care provided (required in law), incorporate the person's wishes and preferences about their care and provide guidance to staff in how a person's needs are to be met.
They have to be legible, relevant and therefore up to date.

In July 2008, ongoing requirements in certain areas of care provision and record keeping resulted in enforcement action being taken by the former Commission for Social Care Inspection (CSCI) in order to secure compliance with the Care Home Regulations 2001. By December 2008 many of these requirements had been met and compliance in other areas of care was being maintained. However, a requirement was made again in December for care plans to give clear guidance to staff in how a need is to be met and for these to be appropriately reviewed. At the same time a requirement was made for staff to be clear about how someone was to be safely moved and for any care plans or assessments relating to someone's safe moving and handling to demonstrate this.

In this inspection we evidenced several shortfalls in people's care planning that appeared to originate from a poor and contradictory assessment process (see outcome above). This meant that some people's actual needs were just not acknowledged, such as someone's continence needs.
It also meant that some potential problems, such as people's nutritional risk, mobility and susceptibility to pressure sores were left without clear guidance on what the actual problem was and how this was to be addressed.

An example of this confusion was seen in one person's care file relating to their continence needs. In the local authority's assessment of needs this person was assessed as being incontinent of urine and faeces at times. Within the home's Physical and Social Assessment, completed the day after admission, only faecal incontinence was acknowledged. In the Pressure Area Assessment they are assessed by the home as being fully continent; the same in the Falls Risk Assessment. In the person's Dependency Assessment they are described as having full control of their bladder.
We visited this person's bedroom and it smelt very strongly of urine. We spoke to the member of staff who had completed these assessments and they were unaware of any problems but confirmed they had been aware of the strong smell of urine in the bedroom. There was no specific care plan addressing continence. The aim of the care plan addressing personal hygiene was for the person to remain continent and to maintain privacy and dignity, but only went onto described to staff the areas of the person's body they needed to wash.

Information on another person's pre admission assessment said they wear continence pads and are 'dependent'. In this person's case there was no care plan giving guidance about this and the dependency assessment was only half completed.
We visited this person at 10.40am to find them very distressed and confused, waiting for help. A carer came in soon after we arrived and said she was there to help the resident get dressed. This carer also explained that although they were aware of care plans being in the office, they did not always have time to read these and tended to find out what people's needs were once they started helping them, particularly those in for respite who

do not stay for long. This carer was very kind and patient in her approach and explained to the person why they were staying in the home.

The majority of another person's assessments and care plans were completed by staff on the last day of this inspection (17/06/09), after the person had already been in the home for four days. The home's dependency assessment and pressure area assessment said the person was incontinent of urine during the day. There was no associated care plan for this.
The pressure area assessment identifies the person at being risk of developing pressure sores and a further note said 'increased since their last stay in the home'.
Further records said the person required a walking frame to transfer and a wheelchair for longer distances. This person was also diabetic. A entry in the care file dated 13/06/09, the day after this person's admission, records the visit of an external healthcare professional, in relation to the person's diabetes.
In the records dated 16/06/09 (we presume the night nurse started writing these before midnight) it states that the person's 'blood levels' are 'currently high' and there were instructions to liaise with the Community Diabetic Nurse if these levels regularly exceeded a certain level.
There were no daily notes for the four days already spent in the home. It was confirmed by the Registered Manager that these records had not been completed on admission.
We therefore take it that a person with several potential problems and some specific needs did not have clear care plans for staff to follow.
We also presume from this, that the information and instructions relating to the person's diabetes were being written in retrospect. This is poor and dangerous practice.
We went down to this person's bedroom at 11.35am to find them in the armchair with their dressing gown pulled up under their chin. The room was noticeably cooler than the rest of the home and the bed was unmade. We asked if they were cold, to which they replied yes. They were sitting opposite a three quarters full commode of urine, which had the lid off so we take it from this that a commode is used at night as was identified in the local authority's assessment of need. During our time with this person a carer came in and we asked why this person was not yet washed and dressed. The carer told us the person had requested to get up later. This was denied by the resident, who told us they had been waiting for help and wanted to get up. They were able to confirm they had had breakfast and we could see crockery to one side.

Further confusion was seen in another person's file in relation to their mobility. The care home's pre admission assessment said that the person walks with two sticks, the local authority assessment of needs, mentions the person being unsteady on their feet in the morning. The home's moving and handling assessment does not mention the sticks but the 'safe working systems', part of the same assessment mentions a walking frame for going to the toilet and comments that there is no risk with this.
The subsequent care plan says 'can walk well with sticks, no supervision needed'. There was no mention of a walking frame.

One of the areas of last year's enforcement action related to poor wound care practices and shortfalls in its record keeping. The care home changed its wound care records, trained staff in correct wound care recording, with help from external healthcare professionals and improved the records and systems for wound care generally.
To ensure this was maintained they started to audit the wound care records on a weekly basis, making sure that all areas of the documentation were correctly completed and that

wound and dressing reviews were being carried out on the date specified. This was seen by us as a positive initiative and good practice.
During this inspection, whilst examining other care plans for one person we looked at their wound care records. We saw an entry dated 16/04/09 in the wound care plan which reported a broken area of skin to the base of the person's heel. It said that the cause was unknown. The measurement at that time was given as 1 ½ (one and half) cm x 2cm.

On 20/04/09 a picture was taken of the area showing that it had got slightly larger and the record then suggested that this may be part of the person's existing skin problem or a that it was a pressure sore. Records and pictures after this date clearly show and describe a pressure sore that initially got worse.
The last entry in the wound progress report was dated 19/05/09 where the record talks of the wound being the 'same length and width with 10% slough'. According to this record and previous ones recorded, this was an improvement and the record indicated that the wound was healing.
On reading the care plan evaluation for the 23/05/09, this again reported the presence of slough on the wound and went on to give guidance to staff on what dressing to use to deal with this.
From this date onwards these records then only proceed to talk about the treatment of the other skin complaint. On asking the nurses on duty if they were aware of the current condition of the heel they were not, so we asked to see it with the permission of the person. We found an obvious pressure sore about 2cm x 2cm with a degree of depth to it. The nurse present agreed it was obviously a pressure sore, she said she would dress this immediately, which she did. This wound had been undressed in slippers that were damp from the fluid draining from the legs, connected with the other condition.
We were very concerned to see a repeat of last year's problems where wound care records were incomplete and wounds were not receiving adequate care.
As we knew about the wound audits that had been introduced last year we asked to see them from the week of 14/05/09 up to this inspection date.
The Registered Manager was unable to locate these in the folder they should have been in. After he had contacted the senior member of staff responsible for completing these we were informed that they had not been completed since the week of the 14th and the member of staff was unable to give an explanation as to why they had not been done.
We asked the Registered Manager to follow this omission up appropriately and in the meantime we requested that an update be done on all wounds currently being attended to. This was done to reassure ourselves that all wounds were being reviewed, but also so that that the Registered Manager was updated in this area as it concerned us that he did not know that the audits had not been completed.
The review showed: one person had suffered blistering to the top of both feet, thought to be caused by continual crossing of the legs. One area had healed and the other required a dressing for protection and monitoring to ensure it did not develop in to anything further.
Another person had a skin flap injury to their elbow which was due to be reviewed on the day of this inspection and had last been seen five days previously on 07/06/09 (five days maybe appropriate with certain dressings). This person along with one other, was at risk of developing pressure sores in areas where they had already had problems, so remained on previous audits so that senior staff could be sure that vulnerable pressure areas were being monitored. By the audits not being carried out for the last four weeks this had placed these people at risk.
One other person was due a review of a chronic wound site on 13/06/09 and another person had a dressing to the mid leg area which was also due a review.

After this we were concerned that people who were at risk nutritionally were also receiving the monitoring they required. This had been another area requiring enforcement action by the Commission to secure people's safety in 2008. We asked for the nutritional audits and saw that they had been maintained weekly with the last being completed on 06/06/09. We cross referenced one person's weights, as seen on the audit, with the weights and nutritional assessment in the person's care file.
This showed an initial loss of weight in April of 3.3kilograms, which is why this person was being monitored weekly and subsequently on the audit. From mid May and onwards we could see that a steady weight gain had been achieved despite this person's frail state, which demonstrates the benefits of ensuring that people who are at risk are highlighted and additional support is given.
There was also an appropriate care plan in place.

The kitchen staff were aware of this person's needs as they were for many other people requiring various diets.
People's specific diets were clearly written on a blackboard and included those that required additional calories, low fat and low salt diets along with several diabetic diets, soft and pureed diets.
We spoke to one person who requires their food to be pureed for health reasons and they confirmed that this is generally achieved each day. This person gave praises to one member of the kitchen staff in particular who they said, goes out of their way to make mealtimes a little more special by going to visit them if they cannot eat what is provided and asking them what they fancy to eat.

We became aware of three people where we felt that either a particular incident had been preventable or where a specific risk had not been addressed. Our concerns were heightened as one of the incidents appeared to mirror concerns we had had in January 2008 and which resulted in further action being taken by us to secure this person's safety.
All three incidents were evident when inspecting the home's accident reports.
Two separate accident reports told us that one person had left the building on two separate days in March of this year. Both took place at busy times of the morning, where the person had left the home and had suffered a fall in roads local to the care home. On each occasion a member of the public had kindly returned the person. Slight injuries had been sustained and on one occasion the report tells us that the individual was confused and agitated on their return.
The person's family and General Practitioner had been informed each time which is good practice. We were unaware of these events and the Registered Manager admitted that they had not been reported, as they should have been, under Regulation 37 of the Care Homes Regulations 2001 as an adverse event that affects someone's health, safety and wellbeing.
In this person's care file was a letter from the Consultant Psychiatrist, dated March 2009 clearly outlining the person's condition and acknowledging that the present care home cannot properly meet the person's specific needs any longer. During this inspection we asked what had been planned following this letter and more importantly, what the care home had put in to place to maintain this person's safety and wellbeing. We had looked for a relevant care plan and risk assessment to tell us this but could not find one. Our concerns were heightened as these incidents mirror concerns we had had in January 2008 for another person, where the home were unable to demonstrate what they were doing to ensure the person's safety.

In the case of the person in 2008 it resulted in us making a safeguarding adults referral and an assessment of the person's needs being reviewed and monitored by external healthcare professionals. We also took enforcement action to increase the staffing within the home (see Staffing outcome).
The Registered Manager informed us that the person we were concerned about during this inspection was not being moved from the home because they had settled since the event. This was excellent news and we appreciate that some people wish to remain in a certain geographical location but, we still remained concerned that: a) the home were effectively caring for someone they were not registered to provide care for, i.e. they are not registered to care for people with dementia b) they had not given notification of the two events to us and more importantly, c) they still could not demonstrate how they were planning to maintain this person's safety in the future, as was the previous issue in 2008.
We have subsequently made a referral to the Safeguarding Adults Team to ensure this person's safety and welfare is reviewed by appropriate healthcare professionals.
The care plans for this person were virtually illegible to both the Registered Manager and us. What we could read made no sense and the Registered Manager confirmed that these would be re- written following this inspection.

We were drawn to the second person who was sitting in one of the communal areas because of the remains of what must have been extensive bruising to their face. The person was unable to tell us what had happened to them.
The home's accident report told us that this person fell forward and out of a wheelchair that was being pushed by a member of staff on 25/05/09. We were alarmed by this as such an accident should have been preventable. We were also concerned that we had not received notification of this event, which the Registered Manager admitted during this inspection that he had not done this. In February 2007 a similar situation occurred when someone sustained severe facial bruising following a fall. We were not informed then and a requirement was made as part of the Random Inspection in March 2007. We also note that a requirement was made in July 2006 in relation to Regulation 37. The Registered Provider should be fully aware that any adverse event or serious injury, affecting a person living in the home, must be reported.
The Registered Manager explained that he was not surprised that the bruising was still evident as the person had suffered extreme bruising to the face and had been in a 'terrible mess' at the time. During this inspection we met a close relative of this person who confirmed the extensiveness of the bruising following the accident. They also informed us that they had made a complaint to the Registered Manager because they had not been happy with the two explanations given by staff, as to why the accident had occurred (see outcome for Complaints and Protection).
We were informed by the Registered Manager during this inspection and read on the complaint investigation record that the person's care plans and appropriate assessments had been reviewed and amended and that staff had been spoken to.
The Registered Manager told us that an amendment had been made to the care plan, directing staff to not only have two staff transferring the person, but also to make sure two staff remained with the person during transportation and, if the person was to sleepy, to leave them where they were until they were more awake.
We looked at the relevant care plan which had an original date of 23/07/08 and it did say that two staff were required to transfer the person into the wheelchair but, there was no recent amendment to include two staff remaining with the person during transportation or direction to leave the person until awake, if sleepy.

We also looked at the falls risk assessment and this had not been amended since the accident (last review in April 2009)

The accident form implies that the person was so sleepy that they fell forward, out of the wheelchair during transportation. If this was so, the judgement of the staff involved in transferring someone so sleepy into a wheelchair and then transporting them has to be questioned.

We pointed out that the accident form had been completed by the nurse in charge who also, according to the accident report, was the only witness. We therefore asked for a record of the conversation that took place with this member of staff, as would have been required as part of the complaint investigation and of any other conversation with any other staff on duty at the time. We wished to know what had been discussed and what action was taken. The Registered Manager acknowledged at this point that he had obviously not amended the care plan as planned and he had not made a record or supervision record of the conversation held. He did confirm that he had spoken with the member of staff involved and one other. We asked who this had been and at this point he could not remember. Later we were given a name of a second member of staff who had been on duty and again there was no record of any conversation held. The Registered Manager told us that he had spoken to all staff in the shift handover in the morning about the accident.
This poor and inadequate practice (see outcomes for Complaints) and leaves the person at risk.
As we could not see any record to the effect we asked when the General Practitioner had been consulted about the person's serious bruising to their face. The Registered Manager explained that this had not been done as it was not felt necessary. He explained that as there had been no subsequent symptoms, it was unlikely that any serious injury had been sustained. We asked how that conclusion had been reached if the person had not been examined by a medical practitioner. We were told that it was 'one of those nurse decisions made at the time'.
We asked if the person had been in pain following this accident and we were told that the person had not expressed any. When we spoke to this person earlier, although very sociable and chatty, they were unable to verbally communicate in a way that one could follow or lead on from.
The practice throughout this incident and following it has in our judgement serious shortfalls, which have led us to make a subsequent referral to the Safeguarding Adults Team to ensure this person's care and safety is followed up by appropriate healthcare professionals.

The third accident form, completed in February of this year, stated that the person 'slipped from the sling of a hoist' and sustained a superficial cut to the back of the head.
We again had not been notified about this and as a piece of equipment was involved it should have also been reported to the Health and Safety Executive under RIDDOR (Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1985). The Registered Manager during this inspection said he could not recall the incident.
We spoke to two care staff who were assisting this person at the time of this inspection and they had no recollection of ever needing to use a hoist on the person, although they could recall the person being unwell a few months earlier. They told us that the person now transfers with the aid of two staff and a frame.

We looked at this person's moving and handling assessment. This had initially been carried out in March 2008 with subsequent reviews dated 23/11/08 and 23/12/08. On the second page we could see a date of 23/11 where a possible over write had been made changing the assessment from 'uses Zimmer frame and help of 1 carer to 2 carers' in relation to getting out of bed.
On the third page of the assessment, alongside a date of 23/11 it says 'transfers with the help of 1 carer using Zimmer frame' and this was in relation to transferring from bed to chair, chair to wheelchair. There was no mention of the use of a hoist ever.
The care plan for 'risk of falls' originally dated 07/04/08 had a review date of 22/03/09 spoke of a fall happening at some point and says there should be 2 carers for transfers and this is repeated in a review carried out on 05/04/09, which is what the care staff had said. We examined daily care notes for the period of the accident and these did not refer to a hoist being used.
We left the above incident to be investigated by the Registered Manager. We remain concerned again, about the Registered Manager being unable to recall the event, as he had previously informed us in a past inspection that all accident reports are audited by him within 24 hours of event. This accident report should have rung alarm bells due to the potential seriousness of someone slipping through a sling whilst in a hoist and should have resulted in an investigation.

We spoke to one person who has a deteriorating condition and who is able to express choices in how they wish to be cared for. We initially visited this person on the first day of the inspection. We read that a specialist healthcare professional had visited to organise an appropriate pressure relief mattress and cushion. The person was able to tell us about this and why this was being done. They also spoke to us about their last visit to their Consultant and how they could now have pain relief medication 'up to hourly' if needed. The person commented that some nurses did not understand a request for pain relief saying either it was not due or trying to persuade them to wait a little longer. When we spoke to senior staff about this they wondered if some staff had misunderstood the 'up to hourly' instruction and taken it to be 'up to two hourly'. The Registered Manager said he would review how this had been written on the medication administration record, to ensure there were clear instructions.
When we looked at the associated care plan this was non specific with comments like 'give as per GP's prescription' and it was also still referring to the pain relief medication that was being used prior to the Consultant's appointment and which was no longer in use.
The night care plan for sleep also still mentioned the old pain relief and there was no mention of the pain relief that can be taken 'up to hourly' for breakthrough pain. So there had been an alteration in pain relief but the care plans had not been amended to reflect this. The pain relief assessment had also not been done since the alteration in pain relief, which is when one would particularly expect staff to be using this chart.
This person told us that the chair they were sitting in was the fourth one they had tried in the care home and that when it was first brought into the room it was filthy and they had asked for it to be cleaned. They also described how uncomfortable they were in this chair as they needed to elevate their legs and were trying to do this on a stool that had two pillows balanced on it in order to get the height. We could see that the chair seat only came half way along the person's thighs, leaving half the thigh to the knee unsupported. It was in their legs and hips that the person experienced most of their pain, so the seating was important to get right.

The person said he had originally been given a recliner chair which broke and that a different recliner had been promised sometime ago. The person had been told that a recliner had been located but it needed cleaning first. When we spoke to the Registered Manager about this with the resident, on the first day of the inspection, we were informed that out of the five recliners identified in the home four were not working and that the one that was would be organised that afternoon. When we revisited this person the following day the recliner was still not in the room and we were told that a motor had to be ordered. On the last day of this inspection we heard one of the nurses explaining to a carer that a motor has been ordered for the chair but the Registered Manager explained that this was incorrect and that one recliner was in working order and would be supplied to the person.

This is a further example of the disorganisation and lack of communication within this home, which is having an impact on some people living there.

The small table in this room, being used by the person when sitting in the armchair, had a rough edge where the wood was splintering. Apart from the fact that this would be very difficult to wipe clean properly the person said they kept scratching their hand on it. The Registered Manager agreed at the time of this inspection that it needed condemning and would get it replaced. This led onto a discussion about equipment and furniture (see Environment outcome).

Despite this person suffering a deteriorating illness, the paper work that the home has for recording certain wishes, which is good practice, such as communication about pain and pain relief management, any other specific wishes including end of life wishes, religious wishes prior to death and after death were not completed. So we do not know if these things have been discussed with this person or not.
The home's Annual Quality Assurance Assessment (AQAA) tells us that the home is participating in a pilot being run in the county to train staff in care home's in the' Liverpool Care Pathway'. This is an initiative that is hoped to be run nationally in care homes to try and improve the quality of care given to those who are at the end stages of their illness. It is the home's aim to be a resource for other home's in the area once they have completed the training.
We also read that this person had suffered a fall in their ensuite in the care home on 15/12/08 which had led to a hospital admission. They had then suffered another fall whilst in hospital. The moving and handling assessment itself had not been updated since the 02/12/08, a date prior to the falls. The person currently uses a frame to move around from bed to chair and this was mentioned in the 'safe systems of work' documentation.
We saw that this person's nutritional status was being monitored and that the GP was involved in monitoring this.

<u>Pharmacist inspector's report about arrangements for the handling of medicines.</u>

At the time of this inspection no people living in the home were assessed as able to self medicate and look after their medicines so they were totally dependent on the staff for this part of their care. Registered nurses were responsible for handling and administering all medicines for people living in the home. The nurses told us that sometimes people have been helped to look after their medicines if they wished to and where an assessment

showed this was safe. We advised the manager about the sort of records to keep in these circumstances.

During the inspection we saw the nurses administering some medicines to some people living in the home; they had all received their morning doses by 10.30am. Two special trolleys were provided to take the medicines around the home safely. We did sometimes observe staff preparing doses into a small cup in the dining room then taking just this cup (without the medicine record chart) to the bedroom which in one case was on the first floor and so a distance from the trolley. This is not regarded as good practice and could lead to mistakes. On one occasion we had to remind one of the nurses to sign the medicine record when she had administered the dose.
Staff began to administer the lunchtime medicines at 12.45pm and the tea time medicines at 5.15pm. We discussed with the nurses about achieving suitable intervals between doses. It is particularly relevant to make sure of a minimum of 4 hours between doses of paracetamol products. A more equal spacing of doses over the 24 hour period helps get the best effect from analgesics and antibiotics. For example, on the day of the inspection if anyone had any paracetamol for a morning dose at the end of the round at 10.30am they must not be given another dose until 2.30pm yet the lunchtime doses were administered around 1pm. This can therefore have implications throughout the whole day. One nurse told us that in the morning she tried to first give doses to people who also took medicines at lunchtime. Use of two medicine trolleys and two nurses in the morning and lunchtime helped with more prompt administration of medicines but later in the day when there is only one nurse on duty the nurses told us this can take a lot longer. On the day of the inspection there were 41 people living in the home many taking a lot of medicines and needing a lot of support to take them so this is a significant amount of work for the nurses during the shift.
It is also important to observe directions for taking certain medicines in relation to food. We pointed this out to the nurse at lunch time as the tablet she was about to take to one person was labelled be taken with or after food. At that time the lunch was not yet served. The nurse added this information to the medicine chart. We discussed with the manager and some of the nurses about finding out about each person's choice about how they wanted their medicines and if they felt it respected their dignity and privacy to have their medicines administered in public in the dining room at a meal time. One nurse told us she would not administer medicines such as inhalers or eye drops at a meal time and we saw this was the case.
We were concerned during the morning to find an inhaler for one person was left on the breakfast table. In the conservatory we found a medicine measure with pink liquid by a resident who did not know what this was. A carer in here also did not know. The nurses said they did not know anything about the liquid but thought it was a liquid food supplement. Leaving medication around in a care home can be a risk to people living here.

There were arrangements for keeping records about medication received, administered and leaving the home or disposed of (as no longer needed) for each person in the home. Accurate, clear and complete records about medication are very important in a care home so that people are not at risk from mistakes with their medicines and so that there is a full account of the medicines the home is responsible for on behalf of the people living there. We looked at some of the medicine records and were concerned to find that these were not always kept to an acceptable standard.

We found that on the whole routine medicines were generally signed as administered or an explanation was provided if not. This indicated that people living in the home were receiving their medicine as prescribed. Checks we were able to make by counting remaining stock also generally indicated this. We saw very occasional gaps in records we looked at. The manager told us about the checks in place which he feels has led to improvement in these records. We did see examples when medicines with a direction for regular administration seemed to be used only 'when required' but without explanation. Staff had not always recorded what dose of a medicine they had given to people where variable doses (one or two tablets for example) were prescribed.
The doses of a certain medicine (where there were changes following regular blood tests) were only taken over phone and not confirmed in writing as specified by the National Patient Safety Agency although care plans did make reference to these national guidelines). Staff did not seem aware of this so we left further information for them to follow up. Records for dose changes were hard to follow through and not all results were recorded in a standard way. The deputy manager phoned the surgery during the inspection to check about these. This same issue was raised at the pharmacist inspection of medication in July 2006.
Some eye drop directions needed to include which eye. Staff were able to explain to us about this.
There were no routine records made for the application of prescribed external products, which carers generally applied.
Receipt records were missing for some medicines that had come into the home.
The medicine records were not always up to date about the medicines in use or changes to doses. Where handwritten entries were made on the records these were not always dated and signed by the nurse writing them or with a signed check by a second nurse. The manager confirmed this was what is expected.
We saw records for a routine prescribed liquid feed were not always signed but sometimes there was a tick or a question mark. Medicines were administered through the feed tube so this needs to be included on the prescription for the doctor as this is an unlicensed way for these medicines to be administered. If this information is available to the pharmacist on the prescription they are able to provide any additional advice about this.
The treatment for one person recently admitted with two different prescribed artificial tear eye drops (some of them recorded to be used at the same time) needed sorting out with proper directions for use as there would not be any point in instilling both drops in the same eye at the same time.

We looked in some care plans to see what further guidance was included to staff to help with making decisions about using medicines that were prescribed to use 'when required' or with a variable dose. This information was not available or lacked enough detail for all medicines prescribed in this way. This is important so that all staff understand how such medicines are to be used to meet each person's identified needs in a consistent way. We found there was different understanding from staff about the use of an analgesic for example.

Our checks of the controlled medicines record book showed that there were a few anomalies that needed further investigation in order to clarify what was recorded. Stock balance checks were recorded on various pages on 2nd June 2009 but there were no regular stock checks in place. This was a concern and we strongly recommend more

frequent checks. Some of these medicines in stock were not in routine use so if there were discrepancies these would not be picked up quickly and could be hard to follow through.

There were suitable arrangements provided for storing the medicines safely and there was a separate medicine fridge. We were concerned that the two pen devices for insulin that were opened and in use were still stored in the fridge which was contrary to explicit directions from the manufacturers and printed on the labels not to store in the fridge when in use. There were temperature records for the fridge and room which showed that on the days records were entered this was the right temperature to store medicines.
Unfortunately staff had not completed the records every day as they were supposed to.
There appeared to be a lot of stock of some medicines so some better stock control may be necessary in order to avoid waste of NHS resources.
A new wall in the main medicine storage room was still bare plaster. As this is a clinical area this wall needed painting.
The controlled drug cupboard needed securing to the wall with four rag or rawl bolts (rather than the screw head fixings in place) in order to comply with the Misuse of Drugs (Safe Custody) Regulations 1973.

We visited three bedrooms to see how containers of creams or ointments that were in use were kept. None of these containers had dates of opening written on them so regular replacement with new stock in accordance with good practice to reduce risks of contamination was not possible. These containers were not kept in any way to prevent unauthorised or accidental access by other people in the home. We also saw a packet of Rennies in one of the bedrooms. This room was empty and not locked. Our concern is that if there were people living in the home with any degree of confusion this may be a risk if they tried to use these.

All eye drop containers we saw had an opening date and were changed every month in order to reduce risks of contamination. The practice of writing opening dates on other medicine containers was variable. We strongly recommend homes to write the date on any containers of medicines when they are first opened to use. This helps with good stock rotation in accordance with the manufacturers' or good practice directions and with audit checks that the right amount of medicines are in stock. The supplying pharmacy should be able to provide advice about the recommended periods for using various medicines once the containers have been opened.

Staff showed us the lancing devices they used for obtaining samples to measure blood glucose but these were not suitable as described in a 2006 medical device alert. This was despite having a poster on the wall in the office about using the right type of device. The deputy manager arranged to order the correct product from the surgery during the inspection. It was disappointing to find this still as we had raised this as an issue at the previous pharmacist inspection in 2006.

The home has a medicine policy and one of the nurses was able to show us this file. The manager told us that following a recent advice visit from the supplying pharmacist he was making some changes. We gave information about other changes and additions to the policy that would be needed in order for all staff handling medicines to have very clear guidance about how the manager expects medicines to be managed in this home. Issues picked up as a result of this inspection could also be usefully clarified.

Although the inspection showed that there were basic arrangements in place for managing medicines, the range of issues identified indicated a number of weaknesses in the arrangements and some slack practices. Some of our findings could demonstrate some lack of competence that needs addressing. The manager told us that he was trying to organise some more medication training for the nurses and that he had held some group supervision with the nurses about medication. More formal assessment of the nurses' competence to handle, administer and record medicines must be given serious consideration. These issues may also indicate there is not enough staff time to do the job properly.

Daily Life and Social Activities

The intended outcomes for Standards 12 - 15 are:

12. Service users find the lifestyle experienced in the home matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs.
13. Service users maintain contact with family/ friends/ representatives and the local community as they wish.
14. Service users are helped to exercise choice and control over their lives.
15. Service users receive a wholesome appealing balanced diet in pleasing surroundings at times convenient to them.

The Commission considers all of the above key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

12, 13, 14 & 15
People using the service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home aims to meet people's social and recreational needs. They aim to give people choice, but there are times where meeting people's preferences is not successful. The home is well aware of its responsibilities to those that may require support to make decisions and they know where to obtain this support from.

EVIDENCE:

This outcome has been assessed using the Key Lines of Regulatory Assessment (KLORA) as guidance.
On the evidence collected for the previous outcome it would be reasonable to say that some people's preferences are not being met, but for others they are content with the care they are being given and in how they spend their time.
We are aware that it was the goal of one person that they lose weight. During this inspection we received further successful news on this, which has also been achieved by the staff in the home supporting this person's personal wish.
We also spoke to a selection of residents who said they were able to have friends and family to visit as they chose and one person was looking forward to a shopping trip with family on one of the days we were in the home.

The activities coordinator works in this role three days a week, on other working days she is a carer. On the day she was providing activities she explained that she has tried to increase the incoming entertainment by paying for this with money that is raised for the home in different fundraising events in the year, there is no budget as such for this.
On the last day of this inspection some of the more frail residents had chosen to stay in bed for the majority of the morning so that they could be up a little later and enjoy the show that was coming to the home in the evening.
The home has held another pub evening, which we understand was very successful.
The activities coordinator confirmed, as did some of the residents that the same activities were in place as when we were last inspecting the home. One resident said that they do get bored on the days when activities are not organised. Ideally this provision needs to be at least five days a week for the size of the home and the type of client group.

We observed some mealtimes and watched staff give support to those that required it. We saw one person being fed in bed by a carer who was taking their time and not rushing. Many people ate in the dining room and several ate in other places such as the lounge area and their bedrooms.
We were told by staff in the kitchen that anyone can have a cooked breakfast and one person confirmed that they had enjoyed theirs.
One main option is served each day for lunch, but we saw various alternatives including a ploughman's style lunch that one person had specifically requested amongst several other hot options. The home's Annual Quality Assurance Assessment tells us that it is the aim of the home to provide a more comprehensive menu and a daily request process to give greater choice.
The food looked appetising and hot and most people spoken to said it was always tasty. The food provided at one of the teatimes was of a poor standard once it had reached people at the far end of the building. This was pate on toast, which by this point was drying out and had curled at the edges. It was being delivered on a normal trolley, room by room from a main platter. A carer told us the options were pate on toast or soup then a banana or yogurt.

We are aware that the home has made links with the service that can provide an Independent Mental Capacity Advocate (IMCA). This person can be provided in situations where a decision has to be made but where the person the decision is about lacks capacity and they have either no family representation or there are concerns about the involvement of the person who maybe representing them. This comes under the Mental Capacity Act 2005.

Complaints and Protection

The intended outcomes for Standards 16 - 18 are:

16. Service users and their relatives and friends are confident that their complaints will be listened to, taken seriously and acted upon.
17. Service users' legal rights are protected.
18. Service users are protected from abuse.

The Commission considers Standards 16 and 18 the key standards to be.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

People using the service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

There are arrangements in place for people to make a complaint or raise a concern but the home is unable to demonstrate that they are taking appropriate action in response to these and therefore people remain at risk. This then compromises the other good practices that the care home has in place such as providing staff with training in the protection of vulnerable adults and robust recruitment systems.

EVIDENCE:

This outcome has been assessed using the Key Lines of Regulatory Assessment (KLORA) as guidance.
We are aware of the one complaint already spoken of in the Health and Personal Care outcome of this report. This had been acknowledged but clearly not recorded or acted upon as stated in the complaint documentation.
We are also aware that other concerns were being raised by relatives to the care home. These were expressed initially to the Registered Manager on a verbal basis, each time the family visited. However, a further shortfall involving medication prompted the complainants to complain formally to the funding authority. The funding authority spoke with the relatives and decided to ask the care home to investigate the complaint. The care home responded to the points raised and we read this response as part of our inspection into the care homes complaint management.
The home's Annual Quality Assurance Assessment tells us that the home has had a low number of complaints and that various assessments carried out by the local Primary

Healthcare Trust (PCT) and local County Council indicate that the home manages complaints well.
In the case of the two complaints that we are aware of, they were received, investigated and responded to, however, the action that is recorded 'as taken' by the care home could not always be evidenced as done and in one case it would be correct to say it had not been carried out at all.
In response to some points raised the care home has expressed its intention to alter the way some things are done in order to correct the shortfalls. This inspection has identified that there are still shortfalls in these areas which include admission assessments, general assessments, care planning, staff record keeping and staff communication and therefore it is possible that concerns will repeat themselves, as seen in the organisation of people's bathing preferences as an example.

We are concerned that despite the intention expressed by the care home that it wants to learn from complaints, the points raised in both of the above complaints are in areas of practice and care that have been concerns to us and where for some we have had to take enforcement action to secure compliance with the Care Home Regulations.

We know by talking to staff and by inspecting training certificates that they are made aware of issues relating to the Protection of Vulnerable Adults (POVA). This training has been given to some staff by the local County Council as well as in house. One qualified nurse's records told us that an update in this had been given to this member of staff this year.
On looking at the files of two new staff (see Staffing outcome) we could see that one member of staff had completed this training with a previous employer in 2006, so would ideally require an update and that the other, employed as a senior member of the care team at the end of April, had not received this training yet.
The care home does have a policy on Safeguarding Adults and a policy with procedures on Whistle-blowing which is designed to protect staff who need to report another member of staff if they witnessed any form of abuse.

We are concerned that any of the good practices and initiatives the home has in place, such as those relating to recruitment and training of staff in various subjects, is being seriously compromised by some very poor practices linked to assessment, care planning, care practice, risk management and the management of complaints.

Environment

The intended outcomes for Standards 19 – 26 are:

19. Service users live in a safe, well-maintained environment.
20. Service users have access to safe and comfortable indoor and outdoor communal facilities.
21. Service users have sufficient and suitable lavatories and washing facilities.
22. Service users have the specialist equipment they require to maximise their independence.
23. Service users' own rooms suit their needs.
24. Service users live in safe, comfortable bedrooms with their own possessions around them.
25. Service users live in safe, comfortable surroundings.
26. The home is clean, pleasant and hygienic.

The Commission considers Standards 19 and 26 the key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

19, 20, 22, 25 & 26
People using the service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Although people live in a home that is generally being maintained and which is trying to improve its environment long term, disorganisation and poor housekeeping on a day to day basis is compromising people's safety and, at times, is managing to give an unhelpful, negative impression of the care home.

EVIDENCE:

This outcome has been assessed using the Key Lines of Regulatory Assessment (KLORA) as guidance.
The Registered Provider was fully aware from the beginning of owning this home that it was going to be a long-term project in refurbishment and redecoration, which is not yet complete and remains ongoing.

A lot of work has already been completed, some obvious like the fitting of new toilets, and bathrooms, fitting of new carpets, new bedroom furniture in some rooms, the decoration of some bedrooms and communal areas, new dining room furniture and a summer house. Other improvements, that are not so obvious, but which are costly, have also been completed such as the fitting of new boilers, electrical work and the fitting of individual hot water regulators to each bath and sink as required to avoid scalding to older skin.
There are future plans to improve the lighting in some areas of the home, replace the current call bell system and continue with decorating bedrooms that have not yet been done.

However, we have received some comments from visitors/relatives that the care home looks shabby and does not smell very nice at times.
During this inspection the area known as the extension remained untidy and cluttered as it has in the past. Currently, not officially in use as a communal area for people that live in the care home, it is being used to store beds, mattresses, hoists, furniture, dismantled tables and air mattresses. A degree of general rubbish was also seen such as rolled up and used plastic aprons, noticeable amounts of debris on the carpet and a couple of forgotten mugs that had dried drink stains. The armchairs in this area were dirty with food debris and other stains seen on them.
Staff seem to be using the far end, a small conservatory, for training and eating in.
Our concern, amongst others, is that people who live in the home, who are sometimes quite confused, still have access to this area, particularly those that are located in the end extension bedrooms as it leads straight off their corridor. It has to remain unlocked as it is a fire escape route and at the time of this inspection the fire doors were clear, but the route towards them a haven for potential trips and falls.

The communal rooms in use did not smell and were being cleaned. They looked comfortable and people had access to outside if they wished to sit on the patio areas.
We did need to point out that one particular bedroom had a really strong smell of urine in it which could be smelt in the small corridor outside.
One communal toilet had clearly not been cleaned properly between our visits. The toilet bowl was clean, but built up urine spillage remained on the china between the cistern and the seat and areas of the floor, to the side of the toilet, were sticky.
On one visit to this toilet there were no paper towels, but these were seen in other toilet areas along with plastic aprons, gloves and hand cleaning preparations for staff use. The rubbish bins also had the correct disposal bags in use.
One ensuite we looked at was particularly tired and because of this gave the impression of not being overly clean, although we know it had been cleaned that day. There are some bedrooms, yet to be decorated or improved that can give this impression.

There seems to be a general disorganisation in the home and possibly a lack of good auditing/oversight and definitely a lack general housekeeping. This is reflected in the observations made above and in examples such as the person who required a different chair for their comfort, as spoken about in the Health and Personal Care outcome of this report. If the care home were organised and thorough cleaning systems were in place, there would not have been the confusion about which recliner chair worked, the one that did work would have automatically have been clean as should have been the other chair that was previously provided. Bedside tables that are splintering should simply not be use.

As we have reported, daily cleaning is being done but clearly only in the obvious areas but to what standard if armchairs get as dirty as those seen in the unused area.

One of the complaints (spoken about in the Complaints outcome of this report) said the home was of a dirty appearance. We were interested to note the response to this by the care home, which mainly addressed this by describing the redecoration and refurbishment work that has been done.
It then goes onto say: 'we have had a recent infection control inspection by the local PCT (Primary Healthcare Trust) and have not had the homes overall cleanliness commented on.
However, we were shown another audit during this inspection that had been carried out by someone else on behalf of the care home, and it comments: 'cleanliness is not good'.

We asked the Registered Manager if the home holds a list of where their specialised equipment is currently being used. We were told there is not one but it was known where rented pressure relief mattresses were and where those that had been supplied by the health authority were. The home does provide basic specialised equipment and it would be helpful to staff to know at a glance where this was at any given time.

During this inspection we observed tiles off in the kitchen above the door, some were off in the main toilet area on the ground floor and we saw an exposed area of ceiling, in the main hall area on the ground floor, where ceiling tiles had been removed leaving an exposed ceiling area above and those that remained, along with one wall, were heavily stained. On asking one member of staff they were unsure as to what had happened. On asking the Registered Manager, he explained that the water gullies that help rain water drain away in the tower area of the building had become blocked and the water had built up and eventually fallen through the ceiling. He explained that work was in progress to remedy this. There were also valid reasons for the missing tiles and we acknowledge that things like this will happen. We are of the opinion however, that the home is not as clean as it could be and that certain areas are not being presented well. We also feel it would be helpful if communication between the management and staff were improved. This way visitors can be given reassuring explanations for things that they see and 'residents' and staff would not feel they need to go elsewhere to get action.

We had been informed during this inspection that the extractor fan for the cooker had been out of action for in excess of two months. Kitchen staff told us that they had been advised not to use the cooker without a working extractor by a visiting engineer. We were informed that they had started to feel unwell and because they did not feel that the situation was being adequately addressed had refused to use the cooker on one particular day. On the last day of this inspection it was working and we were told by the management staff that they had been waiting for estimation on the costs to repair this which had never materialised. We are still unsure as to why it was out of action for so long, why staff felt they needed to contact us in order to get some recognition of how they felt and how it was eventually rectified by the home maintenance person.

Staffing

The intended outcomes for Standards 27 – 30 are:

27. Service users' needs are met by the numbers and skill mix of staff.
28. Service users are in safe hands at all times.
29. Service users are supported and protected by the home's recruitment policy and practices.
30. Staff are trained and competent to do their jobs.

The Commission consider all the above are key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

27, 28, 29 & 30
People using the service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home's recruitment practices are helping to protect the people living in the home but staff mix and numbers are not adequate at times and staff are unable to provide the care and maintain documentation to the standard to which they have been trained.

EVIDENCE:

This outcome has been assessed using the Key Lines of Regulatory Assessment (KLORA) as guidance.
The care staff are friendly and well meaning and are viewed this way by visitors and those that live in the home.
All staff receive training in mandatory subjects such as fire safety, moving and handling, protection of vulnerable adults and various elements of health and safety. Additional training and support has been given at various times by the Care Home Support Team and includes such subjects as nutritional risk and its management, and dementia awareness.

We were informed by the Registered Manager during this inspection that there are enough staff on duty at any given time. We do not agree with this in respect of the qualified nurses in the afternoons. On the first day of this inspection the medication round was started at teatime, approximately 5.00pm, and completed by the one nurse on duty at 6.50pm. Nurses explained that they struggle to give their attention to people who really require it. An exacerbation of someone's mental heath needs resulted in an incident taking place

over the weekend prior to this inspection was a good example of where the nurses continued skills were required for that one person.
The care documentation is not satisfactory as described in this report and one of the other reasons for this could be that staff just do not have time to concentrate on this. It is a requirement under law that Registered Nurses maintain their responsibilities in relation to good record keeping. The nurses on duty understood this but explained that when they have to prioritise, the paperwork will always come last. This is an unfair predicament to be in and we discussed our concerns in early 2008 about only one nurse being on duty in the afternoon. These concerns then resulted in an Immediate Requirement being issued by us to increase staffing generally and to have two nurses on duty in the afternoons for a period of time. This was complied with but the Registered Provider also brought in other initiatives to ensure people's safety and one was to not use the extension end of the property. Staff therefore had less building to monitor.
During this inspection there were 41 people living in the home. The staffing numbers were 6 care staff and two nurses on duty in the mornings and 6 care staff and one nurse from 2pm. We were informed by staff that this had been 5 care staff and this had been very difficult.
One of the cleaning staff wished to work as a volunteer from Monday until Thursday, between 3pm and 6pm and now helps with providing drinks and other simple non care tasks.
The Registered Manager explained to us that the Deputy Manager was leaving the home in two weeks time and they were advertising for a new Registered Nurse. He did say that after this two nurses in the afternoons would be reconsidered.

The home's Annual Quality Assurance Assessment (AQAA) tells us that 80% of the care staff hold the National Vocational Qualification (NVQ) at Level 2 and further staff are due to start this at Level 3.

Where recruitment and retention has been a struggle in the past the home seems to be going through a stable period and it currently has a team that has worked together for a while now.
Recruitment has been more local and recruitment practices have been carried out well. We inspected the recruitment files of two people who had been employed since our last inspection. Both had been employed following checks with the Criminal Records Bureau (CRB) and the Protection of Vulnerable Adults (POVA) list.
Both had satisfactory references received prior to starting employment.
Any gaps in employment had been explored and the reasons documented.

Both these staff were receiving forms of induction, one had attended an induction course externally and was to be mentored by a senior carer and the other was shadowing an experienced member of the nursing staff.

Management and Administration

The intended outcomes for Standards 31 – 38 are:

31. Service users live in a home which is run and managed by a person who is fit to be in charge, of good character and able to discharge his or her responsibilities fully.
32. Service users benefit from the ethos, leadership and management approach of the home.
33. The home is run in the best interests of service users.
34. Service users are safeguarded by the accounting and financial procedures of the home.
35. Service users' financial interests are safeguarded.
36. Staff are appropriately supervised.
37. Service users' rights and best interests are safeguarded by the home's record keeping, policies and procedures.
38. The health, safety and welfare of service users and staff are promoted and protected.

The Commission considers Standards 31, 33, 35 and 38 the key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

31, 32, 33, 35, 36 & 38
People using the service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

In many ways the home is aiming to improve its service but evidence gathered in this inspection demonstrate a serious retrograde step in several areas that have been of previous concern. This would suggest that the management are not entirely in control of the service and its systems and there is a direct link to a lack of organised leadership when it comes to the management of some people's basic care and welfare
.

EVIDENCE:

This outcome has been assessed using the Key Lines of Regulatory Assessment (KLORA) as guidance. It is the level of risk that some people experience and the fact that many of the areas identified in this inspection as not complying with Regulations are areas that have required past enforcement action by us that has made this outcome poor.

The manager has been Registered since December 2007. The Registered Provider has owned the home since 2006 and visits at least once or twice a week. We have not been getting any reports under Regulation 26 but this has possibly been due to miscommunication between the Registered Provider and the Commission.
The Registered Provider told us that he has regular meetings with the Registered Manager in which they review both the management of the care home and the business plans.
We were informed at the beginning of this inspection of the company's future plans for the home and informed that a person has been employed on a consultancy basis to help take the home forward.

However, by the end of this inspection we were very disappointed and concerned to see that areas of practice and care that had previously been the subject of requirements or enforcement action by the former Commission for Social Care Inspection (CSCI) to secure compliance against the Care Home Regulations, were failing again.
In respect of our immediate concerns during this inspection, we issued three Immediate Requirements and the Commission will undertake a management review of the service to consider what further action may be needed.

Efficient and effective auditing and quality assurance systems are essential to ensure that shortfalls can be identified quickly and a structured plan of action can be formulated. In the past this has either been inconsistent or absent. Audits relating to health and safety, nutritional risks, wound care management and care planning have been lacking in the past. During this inspection we could see that where consistent auditing has taken place, this has resulted in sustained good practice relating to nutritional risk. It had also been achieved in wound care, but recently this has failed.
The home's Annual Quality Assurance Assessment says that a system for auditing care delivery has been successfully introduced. During this inspection we have evidenced too many shortfalls in assessments, care planning and risk management to be able to agree that people are benefiting from this initiative.

We have been told that Health and Safety audits are completed (we did not see these at this inspection) but did see records that demonstrate that basic Health and Safety checks are taking place such as, checking hot water temperatures, last completed April this year. We know that a general audit of the premises/environment was carried out in January of this year.

The home's Annual Quality Assurance Assessment tells us that relative meetings are taking place and are being actively promoted by a reminder letter being sent to the relative just beforehand.

Training was difficult to evidence again because the filing of staffs' certificates and maintenance of the training records remain disorganised and not up to date.
We have been told that all staff are up to date in safe moving and handling and we saw a pile of internal certificates for this.

We saw some supervision records which indicate that staff are receiving supervision sessions, but we were concerned that specific supervision, that is clearly required after certain incidents and complaints, had not been recorded and indeed we were unsure as to what had been discussed in these situations. This seems to partly contradict the home's

statement in its Annual Quality Assurance Assessment which says: ‘we have increased the use of staff supervision to support and develop qualified nurses and carers’.

During this inspection we observed staff being spoken to in a manner that is not constructive. At times staff were spoken to in a dismissive and belittling manner, which has been witnessed by us on more than one occasion. This gives us a clear impression that at times the management are not overly approachable. Communication in the home is clearly poor and we would question if this approach is having an impact on the effective leadership of the home.

The information supplied to us by the home in their Annual Quality Assurance Assessment (AQAA) is very informative and reports many positive achievements and goals. However, our evidence suggests a different picture in practice and that the management team are not learning from their previous shortfalls.

We are aware that the Registered Manager is still standing in for nursing shifts that require covering. In the past this has included some night duty. Whilst we recognise there can be some value in doing this from time to time, we have made a recommendation before that this added pressure is removed, leaving the Registered Manager purely able to concentrate on managing this busy care home in an organised fashion.
We have repeated this recommendation in this report. We are also aware that the Deputy Manager is leaving soon and the extra support given to the Registered Manager by this person will not be there until the home completes its recruitment process.
It is very important at this stage, that the management team concentrate on and address the requirements and shortfalls identified in this report.

We inspected the electronic records and monies held for safe keeping for five people. This is managed by the administrator and all were correct.
There is no-one under the care of a public guardian through the Court of Protection.
Several people have nominated Power of Attorney and the care home’s administrator was aware of who these are.
We would recommend that monies given in payment i.e. to the hairdresser are followed up with a receipt. We saw receipts for Chiropody.

SCORING OF OUTCOMES

This page summarises the assessment of the extent to which the National Minimum Standards for Care Homes for Older People have been met and uses the following scale. The scale ranges from:

4 Standard Exceeded (Commendable) **3** Standard Met (No Shortfalls)
2 Standard Almost Met (Minor Shortfalls) **1** Standard Not Met (Major Shortfalls)

"X" in the standard met box denotes standard not assessed on this occasion
"N/A" in the standard met box denotes standard not applicable

CHOICE OF HOME	
Standard No	***Score***
1	X
2	3
3	1
4	X
5	X
6	N/A

HEALTH AND PERSONAL CARE	
Standard No	***Score***
7	1
8	1
9	1
10	3
11	2

DAILY LIFE AND SOCIAL ACTIVITIES	
Standard No	**Score**
12	2
13	3
14	3
15	3

COMPLAINTS AND PROTECTION	
Standard No	**Score**
16	2
17	X
18	2

ENVIRONMENT	
Standard No	***Score***
19	2
20	2
21	X
22	2
23	X
24	X
25	3
26	2

STAFFING	
Standard No	**Score**
27	1
28	3
29	3
30	3

MANAGEMENT AND ADMINISTRATION	
Standard No	**Score**
31	1
32	2
33	2
34	X
35	3
36	2
37	X
38	1

Are there any outstanding requirements from the last inspection? Yes

STATUTORY REQUIREMENTS

This section sets out the actions, which must be taken so that the registered person/s meets the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The Registered Provider(s) must comply with the given timescales.

No.	Standard	Regulation	Requirement	Timescale for action
1	OP3	14	People's needs must be fully identified and then assessed, correctly and comprehensively so that staff receive the correct information and so that care plans are relevant to the person's needs and abilities.	31/07/09
2	OP7	15(1)	Each service users' needs must have a written care plan. Where possible this must be devised following consultation with the service user and or their representative so that their preferences/choices can be recorded and understood. This plan must clearly indicate how a particular need is to be met and it must be appropriately updated as required. (Timescale of the 01/01/09 not met)	31/07/09
3	OP7	13 (4)(c)	Staff must receive clear guidance on how a person is to be moved or how they move themselves; this should be clearly stated in all relevant assessments and care plans. (Timescale of the 01/12/08 not fully met)	31/07/09
4	OP8	12	Staff must be able to recognise a pressure sore and then treat it and monitor it correctly.	17/06/09
5	OP8	12	A person's discomfort and pain must be acknowledged by staff, resulting in staff providing whatever is required to help relieve this.	17/06/09
6	OP8	12	Specific risks to people's health and	11/06/09

			safety must be assessed and the home must be able to demonstrate that the person's care plan acknowledges this risk and gives guidance to staff on how this risk is to be either eliminated or reduced. (Immediate Requirement issued on 11/06/09)	
7	OP8	12	People who are obviously injured or present with an injury after an event must be assessed by a medical practitioner to ensure they have not got an injury that requires medical intervention or pain relief. (Immediate Requirement issued on 11/06/09)	11/06/09
8	OP9	13(2)	When medicines are administered to people living in the home staff must always follow practices that are safe and in accordance with best practice guidance and that medicines are given at safe and effective dose intervals and correctly in relation to food. This will help to make sure that people are not put at unnecessary risk from medicines because of poor practices.	31/07/09
9	OP9	13(2)	Always keep accurate, clear and complete records about any medication received into the home and administered to people who live in the home. (This particularly refers to the shortfalls identified in the report in respect of keeping proper records for prescribed treatments applied to the skin, always recording doses administered where a variable dose is prescribed, keeping dose directions on the medicine charts up to date and with full information for any staff to know precisely how to administer medication in accordance with the doctors' directions). This is to help make sure all medicines are accounted for, that people receive their prescribed medication correctly and are not at risk of mistakes with medication because of poor recording	31/07/09

			arrangements.	
10	OP9	13(2)	Review medicine records and care plans for people living in the home to make sure that for all medicines prescribed with a direction 'when required' or with a variable dose there is clear, up to date and detailed written guidance available to staff on how to reach decisions to administer the medicine and at a particular dose, taking into account the provisions of the Mental Capacity Act 2005. (This particularly relates to some care plans not including all medicines prescribed 'when required' or some not including enough information to guide staff.) This will help to make sure that there is some consistency for people in the home to receive medication when necessary and in line with planned actions	31/07/09
11	OP9	13(2)	Always keep accurate and complete records in the controlled drug record book. This is to help make sure that all these medicines are properly accounted for and people have received the correct doses.	31/07/09
12	OP9	13(2)	Upgrade the wall fixings on the controlled drugs cupboard in order to comply with the Misuse of Drugs (Safe Custody) Regulations 1973. This is to make sure these medicines are stored securely and in accordance with the law.	11/08/09
13	OP9	13(2)	Keep all medicines at the correct storage temperature directed by the manufacturers. (This particularly relates to the storage of insulin injections). This is to make sure that medicines for people living in the home are kept in a safe condition.	31/07/09
14	OP16	17	Any action taken following a complaint investigation must be accurately recorded and the home must be able to, through these records be able to demonstrate that the action stated was actually taken.	31/07/09
15	OP19	13	The premises, in this case internally, must be kept in such a way that people are not put at unnecessary	31/07/09

			risk.	
16	OP26	23	All areas of the home, including the furnishing must be kept clean.	31/07/09
17	OP27	18	Taking in to account people's needs, as well as the number of residents, the home must be staffed with enough suitably competent and qualified staff to ensure that people's health and welfare needs are met adequately at all times.	31/07/09
18	OP31	12	The Registered persons must ensure the care home is conducted in such a way so as to make proper provision for service users' health and welfare.	31/07/09
19	OP31	26	The Registered Provider must monitor the day to day management of the home and provide the Commission with a monthly report detailing the conduct of the home as referred to in Regulation 26 of the Care Home Regulations, until further notice.	31/07/09
20	OP38	37	Any event that adversely affects the well being of someone or serious injury must be reported to the Commission. (Immediate Requirement issued on 11/06/09)	11/06/09
21	OP38	13(3)	When staff take blood samples for blood glucose monitoring for people living in the home the lancing device used must be safe to use in a care home environment as described in Medical Device Alert MDA/2006/066. This is to reduce the known risk to people living in the home of cross infection linked with the use of the wrong sort of lancing device.	31/07/09

RECOMMENDATIONS

These recommendations relate to National Minimum Standards and are seen as good practice for the Registered Provider/s to consider carrying out.

No.	Refer to Standard	Good Practice Recommendations
1	OP7	Make arrangements for a system of auditing/checking for the content of assessments and associated care planning that has an

		effective outcome.
2	OP8	Keep a weekly audit in place of all wound care and its documentation to avoid any omissions in care or recording.
3	OP9	Arrange for dose changes of anticoagulants to be confirmed in writing by the prescriber as detailed in Patient Safety Alert 18 from the National Patient Safety Agency and that blood test results and doses are always clearly and accurately recorded in a consistent way.
4	OP9	Care plans to reflect what choices people who live in the home are given and have made about how their medicines are handled and their consent to the way in which staff administer their medicines.
5	OP9	Make sure that when any handwritten entry is made on medicine charts this is signed and dated by the member of staff writing this with a second member of staff checking and signing as correct.
6	OP9	Write the date on any containers of medicines when they are first opened to use. This helps with good stock rotation in accordance with the manufacturers' or good practice directions and with audit checks that the right amount of medicines are in stock.
7	OP9	Carry out written risk assessments to make sure that when any prescribed creams, ointments and other preparations applied to the skin are kept in bedrooms this is safe for everyone in the home.
8	OP9	Review and update the medicine policy to make sure this is up to date reflecting best practice guidance and includes all aspects for the safe handling of medicines. This is so as to provide all staff with precise direction about the way medicines are safely managed and handled in this home.
9	OP9	Paint the bare plaster wall in the medicine storage room so as to maintain a suitable clean area in which to store medication.
10	OP9	Make more regular recorded stock checks of all controlled drugs so that there is regular assurance that this group of medicines are fully accounted for.
11	OP31	Serious consideration should be given to ensuring that the Registered Manager is completely supernumerary and able to concentrate on managing the home and making necessary changes for compliance and sustaining any improvement.
12	OP35	If payment is made to any person visiting the home for a service, such as the hairdresser, a receipt should be requested as proof of payment.
13	OP36	Provide staff with a minimum of six supervision sessions per year and record when this took place, who carried out the supervision and the subject matter.
14	OP37	Serious consideration should be given to ensuring that important documents/certificates that are required as part of any inspection process are filed and stored in an organised manner, so they can be easily located in the absence of the Registered Manager.

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