

# Medici Healthcare Limited

# Manor Gardens

## Inspection report

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### Ratings

Overall rating for this service	Inadequate	
Is the service safe?	Inadequate	
Is the service effective?	Inadequate	
Is the service caring?	Inadequate	
Is the service responsive?	Inadequate	
Is the service well-led?	Inadequate	

### Overall summary

We inspected Manor Gardens on 27 and 28 January 2015. The inspection was unannounced. Manor Gardens is registered for 64 people. There were 43 people living at the service when we inspected.

Manor Gardens was purpose-built as a nursing home. Accommodation was provided over two floors. Each floor had two separate units, with shared sitting and dining rooms. These four units were managed separately. People cared for in the service were living with a range of complex needs, including diabetes, stroke, heart

conditions and Parkinson's disease. Many of the people needed support with their personal care, eating and drinking and mobility. Some people were also living with dementia. The service also provided respite care to give people and their supporters a break from caring roles. The service reported they provided end of life care at times. There were no people receiving end of life care when we inspected.

There was no registered manager in post. A new manager had been appointed and was in the process of registering

# Summary of findings

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

The service was last inspected on 28 August 2014. At that inspection, we found the service had not met essential standards relating to recruitment of staff, numbers of staff on duty, staff training and support, assessing and monitoring the quality of service provision and records. Following the inspection, the provider sent us an action plan which outlined how they would make improvements in the service. At this inspection, although some improvements had been made, we identified a number of areas of practice which potentially placed people at risk of receiving inappropriate care and support. Risks had not been identified through auditing or quality assurance.

Management systems for medicines were not consistently safe. There were occasions when people's medicines were signed for as being administered and taken when they had not been taken. Inadequate completion of medicines records had been identified several times during audits but this had not led to action. Medicines trolleys were not always locked to ensure secure storage of medicines. Some medicines were not promptly disposed of when they were no longer prescribed.

The service were not following best practice guidelines on moving people in a safe way. Two of the people we spoke with raised issues about how staff supported them in moving. We observed staff moving a person in an unsafe way in front of a more senior member of staff. The person's instructions in their room on how to move them safely had not been updated to reflect their care plan. Similar inaccurate information was identified for another person.

Where people had undergone assessments for bed rails or lap belts, these had not been reviewed to reduce potential risk. There was a lack of best interests' decisions about the use of such devices and other areas of care, including covert administration of medicines. There was no consideration if these matters should be considered under Deprivation of Liberties Safeguards (DoLS). The new manager reported they had identified staff needed

training on the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and had prioritised training in these areas. DoLS are safeguards put in place to protect people where their freedom of movement is restricted.

The service had not identified environmental hazards and had not taken action to reduce risk, for example, risks associated with tripping over. A range of people had raised concerns in relation to security at the service but action had not been taken to address these concerns. While accidents were reviewed, audits had not identified all risk factors, to ensure action was taken to reduce risk.

Some people felt the service was not caring, and they were not involved in planning their care. This related to a range of areas including decisions about personal care. Some staff did not explain the care they were giving to people when they asked. Systems in the home did not consistently support people's dignity, for example net underwear was shared between any people who needed it. However, some people were very positive about the service, one person describing it as "very caring." Other people reported staff knew how to meet their needs.

Most people told us they felt their health and care needs were met. However, we identified people's complex needs were not always managed effectively. This included diabetic care and treatment, prevention of pressure ulcers and supporting people who were living with dementia. Some people's records were not completed accurately, so their needs could not be fully assessed and evaluated. People's social needs were not assessed and documented, so there was no evaluation to assess if people's individual needs were met in this area.

Some people told us the service was not well led, particularly commenting on changes in managers. Although audits of service provision had taken place they did not consistently identify areas for action or detail action plans for improvements. The service's aims and objectives had not been updated to reflect changes in the service. The new manager had started making improvements since they had been in post. For example, they had identified deficits in staff training and supervision. They had developed an action plan and while the service still needed to address many areas relating to staff training and supervision, progress had been made since our last inspection.

# Summary of findings

People commented on the difficulties caused by high staff turnover and communication issues relating to some staff. The new manager had also identified these areas and was in the process of addressing them. People felt there were sufficient staff on duty to meet their needs. This included people who remained all or most of the time in their rooms. Most of the previous areas relating to staff recruitment were addressed. We found one area for improvement in relation to assessing staff suitability for employment before they came into post.

One person told us if they raised issues of concern the new manager would take notice.

The new manager had developed the complaints system and where matters had been reported to them, they performed clear investigations and addressed matters if action was needed.

We saw a few areas where attention was needed to cleanliness, for example bed rail covers. These areas were not included on cleaning schedules. The new manager had developed an audit system for infection control and cleanliness. All areas included on the audit were clean and regularly audited.

Nearly all people commented favourably on the quality and choice of meals. People chose where they ate. Both dining rooms were attractive and comfortable settings for meals. When people needed support to eat and drink, this was provided. The new manager had taken action to identify people who were at risk of not having enough to eat and drink. They had made sure appropriate referrals were made for these people. Where people were assessed as being at nutritional risk, their needs were closely monitored and responses to treatments regularly evaluated.

People commented favourably on the day to day maintenance of the building. The maintenance worker was seen during the inspection, they responded promptly to requests.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

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

We always ask the following five questions of services.

### Is the service safe?

The service was not safe.

People were not consistently supported to move in a safe way. People's assessments for devices like bed rails were not being reviewed. The systems for ensuring people were administered their medicines were not safe. Environmental risk assessments did not identify relevant matters or actions needed to ensure safety.

The new manager had identified action was needed in staff understanding of safeguarding. Action was in progress to ensure cleanliness and infection control. Not all previous shortfalls regarding recruitment had been addressed.

There were sufficient staff on duty to meet people's needs.

Inadequate



### Is the service effective?

The service was not effective.

There was a lack of best interests' decisions and consideration of the Deprivation of Liberties Safeguards where people lacked capacity. There were a range of areas where people's healthcare needs were not being supported effectively.

The new manager had identified a wide range of areas which needed addressing to ensure staff were appropriately supported by training and supervision in meeting people's needs. They had an action plan, which was in progress to address these areas.

People commented favourably on the choice and quality of meals. People who needed support with nutrition and hydration had clear care plans, which were evaluated, to ensure their needs were met.

Inadequate



### Is the service caring?

The service was not consistently caring.

Some people felt they were not involved in decisions about how their needs were met. Some people felt their privacy and dignity was not always supported. Some staff were not caring in their attitude towards people. Certain systems in the service did not ensure people's dignity.

Other people reported the service was caring and they were involved in decisions about their care. We saw some staff were kind and gentle with people, supporting them in the way they needed.

Inadequate



### Is the service responsive?

The service was not responsive.

The service did not consistently respond to people's needs by drawing up appropriate care plans and when delivering care. This included people's needs for activities, as well as complex nursing and treatment needs.

Inadequate



# Summary of findings

People felt they were listened to if they raised complaints. The new manager had set up systems to ensure complaints referred to them were responded to.

## Is the service well-led?

The service was not well-led

Some people told us they did not think the service was well organised. Quality audits did not identify all relevant areas and where they did, action plans were not in place to ensure they were addressed. The service did not ensure they followed relevant guidelines. People's records were not accurate. The service's aims and objectives had not been up-dated.

The new manager was developing systems to ensure people's opinions could be canvassed and communications improved. Several people and staff commented favourably on the new manager.

**Inadequate**



# Manor Gardens

## Detailed findings

### Background to this inspection

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

We visited the service on the 27 and 28 January 2015. This was an unannounced inspection. The inspection team consisted of three inspectors, one of whom was an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with 20 people who lived at the service, five visiting relatives, eight care workers, five registered nurses, the domestic supervisor, the activities worker, two catering workers, the maintenance worker, a domestic worker, the laundry worker, the deputy manager and the new manager. We also spoke with three visiting healthcare professionals.

Before our inspection we reviewed the information we held about the service. We contacted the local authority to

obtain their views about the care provided. We considered information which had been shared with us by the local authority, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We looked at areas of the building, including people's bedrooms, communal areas, bathrooms, the laundry, medicines room and sluice rooms. Some people were unable to speak with us. Most of these people remained in their rooms and were generally cared for in bed. We made observations of how they were, and support they received from staff throughout the inspection.

During the inspection we reviewed the records of the service. These included staff training records, staff recruitment files, medicines records, risk assessments and policies and procedures. We 'pathway tracked' six people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also observed a lunchtime meal, two activities sessions and medicines administration rounds.

# Is the service safe?

## Our findings

We asked people if they felt safe at the service. One person told us they “Used to” but following a recent experience they were not sure if they felt like that anymore. This matter had been referred by the service to the local authority as a safeguarding referral. Other people said they felt safe, one person saying “Oh yes I definitely feel safe.” A person described how they had left money in their clothing when they sent it to the laundry. They had been impressed by the way the laundry worker had found the money and promptly returned it to them.

Two of the people we spoke with raised issues about how staff supported them in moving. One person said some staff were very good but “Others just yank you about – does not matter if they hurt you.” Another person said “Some staff are a bit heavy handed,” when moving them.

We saw two care workers moving a person in an unsafe way. This took place in front of a registered nurse. The registered nurse did not advise the care workers to stop. The information in the person’s room did not relate to the person’s current mobility needs, as set out in their care plan. Another person had a laminated instruction sheet in the front of the records in their room which stated they were not to be moved using a hoist. The information in their care plan contradicted this and stated they were always to be moved using a hoist and sling. All care workers we spoke with reported they used instructions in people’s rooms to tell them how people needed to be moved. While staff had an individual responsibility to ensure people were moved in a safe way, if the information provided to care workers did not relate to people’s current needs, they may not be aware of safe ways of moving a person.

Many of the people we met with had bed rails placed in a raised position. The staff were not following guidelines from the Health and Safety Executive (HSE) and Medicines and Healthcare Regulatory Authority (MHRA) on the high risks to people associated with the use of bed rails. Both authorities emphasise the importance of assessment and review when using bed rails, to ensure people’s safety. The staff were not doing this.

A care worker told us they made sure they always kept one person’s bed rails at the highest position because they had been found at times with their legs over the bed rails. Another person, who staff told us could be restless, had

records which showed they had sustained bruising recently, which was documented as coming from their bed rails. Neither person had their risk assessment for bed rails reviewed to take these risks into account. We spoke with registered nurses and care workers, they reported they did not know about HSE and MHRA guidelines on people’s safety when using bed rails and had not received training in the area.

The issues relating to safety when moving people and the use of bed rails are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about their medicines. Although one person said “Medication is sometimes late,” most people reported they did not have any concerns .

The service did not have full systems to ensure people were given their medicines safely. Records relating to medicines administration were not accurate. We went into a person’s room at 11:15am. There was a medicines pot with several tablets in it. We asked the person what they were. They said they were nothing to do with them and they didn’t know why they were there. The registered nurse said they were the person’s 8:00am tablets. The person had been receiving personal care at that time, so they had left them with them to take later. The person’s medicines chart had been signed to show the person had taken their medicines at 8:00am. The person had recently been reviewed by a community psychiatric nurse in relation to their short term memory loss, but the registered nurse had not taken this into account when leaving the person with their medicines. The staff had not ensured the person had received their medicines at the time they were prescribed for them.

Another registered nurse also signed a person’s medicines record before they had taken the medicine. This registered nurse gave a person a medicine which needed to be dissolved in water. They signed the medicines record to show the person had taken their medicine. This was when the person had only just started sipping the medicine. The registered nurse did not go back to the person to verify they had taken all of their medicine although they had signed the record as having been taken.

Systems for storage of medicines were not safe. We observed three registered nurses administering medicines

## Is the service safe?

at lunchtime. Two of them did not lock the medicines trolley when they were away from it. Both of them did not keep the trolley under observation when they were not with it. This meant medication in the trolley could have been removed by anyone in the vicinity. This practice was contrary to the service's medicines policy. The third registered nurse always locked the trolley when they were not with it.

The medicines room had a cupboard for enemas and suppositories. A spot check of some of these medicines, showed two people had enemas stored which were no longer prescribed for them. These medicines had not been disposed of. Medicines are the property of the person they are prescribed for. Where medicines are held which are no longer prescribed, they may not be used for another person, whether in an emergency or in error.

These issues relating to medicines are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had environmental risk assessments. These were generic and not specific to the service. The new manager reported they were aware of this and was aiming to develop service specific risk assessments. Some areas of environmental risk had not been identified. There was no evidence of action being taken to ensure the safety of people in a range of areas.

There was a noticeable depression in a section of the floor of one of the corridors. Hazard tape had been put down at some point, but the tape looked old and had come off in many parts. One of the inspectors tripped over the area. Many of the people needed support to walk. Additionally some people were living with conditions like Parkinson's Disease which caused shuffling steps when walking. This increased people's risk of tripping on uneven surfaces. We asked the maintenance worker about the area. They told us it had been repaired on at least one occasion but the depression re-appeared. They did not know what actions were being taken to reduce the risk to people. There was no risk assessment or action plan about the area to ensure the safety of people.

A person was prescribed oxygen. They had a large oxygen cylinder in their room. Oxygen cylinders, due to their shape can topple, causing injury and also risk of explosion, unless

secured. Issues relating to unsafe storage of oxygen cylinders had been identified during an external pharmacy audit in October 2014, no actions had been taken as a result. We reported this risk to the new home manager. The maintenance worker ensured the oxygen cylinder was secured by the end of our inspection.

These issues relating to risk assessments of the environment and equipment are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had systems to ensure fire safety, including regular checks on fire maintenance and training and fire drills for staff. Corridor doors were of the type which closed in the event of a fire alarm. Bedroom doors had foot operated devices which held the door open if needed, and they would close in the event of a fire alarm.

There was a clear system for day-to-day maintenance of the service. During the inspection, the maintenance worker was prompt when responding to issues raised with them. A person told us "Brilliant, maintenance man here every day" and described how pleased they were when the maintenance worker promptly mended the toilet in their en-suite.

Prior to the inspection we had been made aware of a range of safeguarding alerts which took place during the past year, both from the service and from others. The new manager reported that one of the areas which had been identified during the investigations was that they needed training up-dates on safeguarding. They had booked themselves onto a local authority course. They were planning to ensure information on safeguarding people and whistleblowing was fully available to staff in key areas of the building, including staff noticeboards.

We spoke with a range of staff to see if they were aware of their responsibilities for safeguarding people. A new member of staff, who was in their second week of induction, did not recognise concepts of safeguarding or whistle-blowing. The induction programme did not identify either area as a matter which needed covering during induction. Some junior staff were also not clear on what they would do if they had safeguarding concerns. The

## Is the service safe?

senior staff we spoke with were very clear on actions they should take. The new manager reported they had identified safeguarding and the whistleblowing procedures as areas which were a priority in their training plan.

We looked at records for three staff who had recently been appointed. All had the required documentation to verify they were suitable to work at the service. Each new member of staff had records of their interview. These showed discussions had taken place about scenarios relevant to their work, and gaps in their employment history had been probed. One person's record showed issues relating to a past criminal record but the person's file had no evidence of investigation or risk assessment of this. We discussed this with the new manager who reported this appointment had been undertaken by an external recruitment agency. They were proposing to the provider that all future appointments be made internally.

We asked people about staffing levels. Comments were positive. We discussed staffing levels with seven people in one dining room and they confirmed staffing levels was not an issue for them. One person said "Yes, always someone here." A person who remained in their room all day confirmed staff came in regularly throughout the day.

There were sufficient staff on duty to ensure general response time when call bells were rung was about 20 seconds. We observed staff supporting people to eat their meals. There were sufficient staff on duty at lunch time so they could give people the time they needed to eat their meal.

However, people reported their concerns about high levels of staff turnover. One person said, "Lots of changes to staff, difficult to get to know staff." Another person said, "Difficult understanding what staff are saying". A relative told us "Good staff get fed up and leave."

The new manager reported on the difficulty of retaining staff in the rural area where the service was situated. They said recent recruitment drives had been successful and the staff numbers were now increasing, but they had a reliance on agency staff to ensure they had the numbers of staff they needed on duty. They reported they were aware of comments about the quality of some staff. They said their staff recruitment agency had been unreliable and they were looking at a replacement agency.

The standards of cleanliness and infection control were variable. We saw some items which were not clean. This included some of the bed rail protectors. Trolleys like linen trolleys, catering trolleys and medicines trolleys, which were moved around the building, had unclean wheels and showed dust adhering to their lower chassis. The male staff toilet had a dirty pull cord.

Some items involved in care were used in a way which could present a risk of cross infection. Full body hoist slings were not named and staff confirmed they were used communally. As hoist slings cross over between people's legs, there was a risk of cross infection.

Across the building in other areas, we saw suitable levels of cleanliness. Surfaces were clean and free of dust. Carpets and furnishings were visibly clean, including undersides of chair cushions. The laundry worker reported all potentially infected laundry was put in the correct type of laundry bags to prevent risk of cross infection. They showed a high level of understanding of risks to infection control in relation in the management of laundry. The domestic supervisor had a clear audit system and they monitored the quality of cleanliness regularly. When we told them about the areas identified which related to domestic services, like checking on the cleanliness of linen trolley wheels, they added them to their cleaning audit.

# Is the service effective?

## Our findings

We met with a person who remained in bed all day, with raised bed rails. They were frail and not able to discuss the bed rails with us. They had a capacity assessment which stated they were able to make “small day to day decisions,” like what they wore or what to eat. They had a consent form relating to bed rails in their records, which they had signed. There was no assessment as to whether they had capacity to retain and understand information relating to the risks associated with the use of bed rails, or if bed rails were in their best interests. Another person who had raised bed rails had an uncompleted consent form in their records. They also had no best interest decision for the use of bed rails. A person had a lap belt round their waist when sitting in their wheelchair. There was reference to this in a care plan, but no evidence of consent for its use, or a best interest decision.

Bed rails and lap belts can present a significant risk of injury to people, so should only be used in a person’s best interests. There was a lack of best interests’ decisions about the use of such devices, although people did have assessments completed in line with the Mental Capacity Act where they lacked capacity.

We spoke with a range of staff. They reported bed rails and wheelchair lap belts equipment was used to keep people safe. They said they were not aware of guidance on the risks relating to the equipment or that it should only be used if it was in the person’s best interests. They had also not assessed that, as these types of equipment can restrict a person’s liberty, a Deprivation of Liberties Safeguard (DoLS) application should be considered.

A person’s records stated they were being given their medicines covertly, which means they were being given their medicines in a hidden way, so they were not aware they were taking them. We asked registered nurses about this. We received varying replies about which of the person’s medicines were given covertly and how they did this. The person did not have a care plan about covert administration of medicines. Registered nurses confirmed they were not aware of a best interest decision taking place for the person before they started covertly administering these medicines. The Nursing and Midwifery Council (NMC) has clear guidelines on covert administration of medicines. The staff was not following these guidelines.

No people were subject to a Deprivation of Liberty Safeguards (DoLS) when we inspected. The service were not following the Mental Capacity Act, 2005 (MCA) or DoLS in the use of potential restrictions on people’s liberty. These issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager reported they had identified, since they came in post, that MCA and DoLS training was an area which needed emphasis. They had started a training programme for all staff so they would be fully trained in these areas, to enable them to be aware of their responsibilities.

People gave us favourable comments about maintenance of their health and contact with healthcare services. One person told us “Staff monitor my blood pressure, they called a doctor immediately.” Another person reported “You can see someone (a health professional) if you want to”.

However, we found a range of areas where people’s health care needs were not being met. A member of staff told us about a person who was living with diabetes whose blood sugar levels “tend to go high one minute and low the next.” The person was living with dementia and was not able to tell us about management of their condition. Fluctuating blood sugar levels can make a person feel unwell and may relate to other medical conditions, like infection. The person’s care plan did not state what actions staff should take if the person experienced high or low blood sugar levels. We asked registered nurses about the actions they would take when the person’s blood sugar levels were high or low. They gave different responses. The staff could not show they were managing this person’s diabetes in an effective way to ensure their health and well-being.

One person was very frail and living with a range of complex medical conditions. They had a record which noted they had developed a “red and infected” area, a week before our inspection. There was no care plan about the treatment of this area. A registered nurse told us details about how they were managing this area. There were no records to show this treatment plan for the wound had been followed. The registered nurse was not able to confirm all registered nurses had been following this verbal care plan, as the service were using agency registered

# Is the service effective?

nurses. The registered nurse reported they had not seen the condition of the person's affected area, so could not tell us about how it was progressing with treatment. The service did not have effective monitoring systems to ensure the person's health and well-being in relation to this wound.

Care and treatment was not planned to ensure people's safety and welfare. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas relating to meeting people's health care needs were effective. There were other people who also had wounds. The new manager reported they had identified wound care was an area which needed development when they came into post. They had set up a process for regular reviews of any wounds. Their audits showed, so long as they were informed about people's wounds, they had put effective treatment, monitoring and review processes in place.

A person had a urinary catheter in place. They had a clear record of when the catheter was changed. Staff had followed manufacturer's guidelines on the changing of catheters, which would ensure the person's comfort and reduce risk of infection.

We received a variety of comments from people about if staff were trained and knew how to care for them. One person said "Some of them are hardly trained" and a relative said their parent was not always cared for in the way they would like. Other people did not echo this. One person told us the registered nurses knew what to do, and another how much they relied on the staff, who supported them in the way they needed.

We observed some practice which indicated appropriate training and supervision of staff had not taken place. This included a registered nurse who on two separate occasions did not promptly dispose of a face mask and continued to wear it round their neck throughout their duties when caring for people and managing the unit. When asked, the registered nurse was not aware their actions could present an infection control risk. A registered nurse shook a tablet into their hand before administering it to a person. They

did wash and dry their hands before or after doing this. We discussed this observation with the new manager. They reported supervision of staff when they performed their role was an area which needed development.

The new manager reported they had ensured new staff were given a role-specific induction. We met with a registered nurse who was working their second shift in the service. They reported they were being prepared for their new role and appreciated being given time to get to know people and their individual needs. A new care worker was in the second week of their induction, they said they were shadowing a senior care worker and starting to do some tasks on their own when they felt confident.

The new manager told us since they came into post during the Autumn of 2014, they had identified staff training needed improvement across a wide range of areas, to ensure people were cared for by staff who were suitably skilled. They said their current priority was to ensure all staff were up to date with training in key areas including safe moving and handling, fire safety and infection control. They had made sure staffing levels were sufficient to free up staff so they could engage in training. Staff we spoke with were positive and felt improvements, like the computer space which had been made available to them to support them in e-learning programmes, was helping them to develop the skills they needed.

The new manager reported they were supporting staff in taking on lead roles for training staff in key areas. A senior care worker had trained to be a trainer in moving and handling people. Registered nurses had been supported to access external speciality training, for example in wound care and syringe drivers.

The new manager confirmed supervision to support staff in their roles had not taken place in the recent past. The deputy manager, who came into post in December 2014, was taking the lead on staff supervisions. They had put a plan in place so all staff received 1-1 support. Their next stage was to cascade supervision responsibilities to key staff, like registered nurses and senior care workers.

While the new manager had made clear improvements in developing strategies which would ensure all staff were trained and supervised in their roles, as these had not been completed, the service remained in breach of Regulation 23

## Is the service effective?

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received a variety of comments about the meals. While a few were less favourable such as “The food is all fancy” or “Soup is not proper soup,” the majority of comments were very positive. One person said “The food is superb, better than I get at home,” another “Puddings are to die for.” A person said they were impressed by the way “The cook comes up and asks you what you want to eat”. A person told us they were living with diabetes. They confirmed, “Yes they give me the right food.” A visiting external healthcare professional told us they were “Confident” about the nutrition and fluids given to people.

The menu choices for four weeks were displayed for people to look at. We observed lunchtime meals. Dining tables were attractively laid out with cloth tablecloths, napkins, metal cutlery and glasses. Staff helped people sit at the tables, offered them a choice of drink and chatted politely to them. People were offered a choice of meal. We saw a care worker cut up a person’s food, having first asked if they would like it done. Care workers supported people if they needed help to eat their lunch, talking with them to enhance the social occasion. One person asked for a small portion and the care worker made sure this was provided.

Some people chose to eat in their own rooms. They were taken meals on trays. We saw steam coming up from meals when the lids were taken off the plate, which indicated they

remained warm. People were offered the support they needed, including ensuring the head of the bed was raised in a way to ensure the person could eat their meal in comfort. When people needed support, staff sat with them talking with them and encouraging them in making conversation. Staff ensured people they were supporting had safely swallowed each mouthful before giving them more to eat, and did not rush them in any way.

Some people were frail and needed support with their diet and nutrition. External professionals including speech and language therapists (SALT) had been requested to assess people when they had swallowing difficulties. When people had been assessed as having difficulties with swallowing, they were given pureed meals and thickened fluids. There was clear guidance for staff on how to thicken fluids. Care workers were fully aware of this guidance and confirmed how much thickening agent they used for each person.

The new manager reported they had identified some people were at risk of losing weight. They had set up monthly reviews when people were losing weight, to ensure their care plans were reviewed and action taken to support them. Records showed people’s GPs were promptly consulted when people were losing weight. For example a person’s records showed they had been losing weight during 2014. Their care plan had been reviewed regularly and action taken to support them during this period. Their weight records showed they were now gaining weight, following the actions taken by the staff.

# Is the service caring?

## Our findings

We asked people about how caring the staff were towards them. Some people said they did not feel involved in making decisions about their care and support. One person reported “Sometimes they just tell you they are going to do it.” Another person described how staff told them about what they were about to do, without asking. One person reported staff tended to volunteer information only when asked, saying “I don’t think they would otherwise.” However another person reported “Yes, I suppose they would,” about if staff asked before they supported them.

Staff did not consistently explain matters to people in the way they needed. We heard a person repeatedly asking for the same information from a member of staff. The member of staff just made the same response several times and did not explain what was going on. The person then asked what was wrong with them, as they needed the support, but the member of staff did not answer.

Some people felt the staff did not support their privacy and dignity. One person said “I don’t have much dignity left.” A relative told us the staff were “Trying their best but in the past they have left my mother exposed.” A different relative told us their loved one “Did have two men undressing her, she did not like that”. However another relative said “I think they offered a choice of man or woman carer”. We looked at a range of care plans, they did not document the person’s preferred gender of the staff supporting them with personal care.

Some people felt they could not make choices about their personal care. One person told us “Not many people have a bath.” The records for one unit showed only 14 showers and one bath had taken place between April 2014 and January 2015. Staff reported most people had washes using bowls. One person had a recently used wash bowl in their en-suite which was named for another person.

An external healthcare professional reported the mouth care given to people was “poor.” We saw one person who had difficulties in swallowing had equipment available to freshen their mouth. However equipment was dry and had adhered to the paper towel it was placed on as if it had not been used recently.

Some people felt the staff did not show caring relationships with them because they did not call them by their preferred name. One person reported “They don’t call me by my

name.” All people had information immediately outside their rooms which included details of their names and how they preferred to be addressed. Despite this, we observed staff varied in how they addressed people. Some staff called people by generic terms of endearment like “love”, “darling”, “pet,” however other staff always addressed people by their own name.

The laundry worker showed us a container of unmarked net underwear. They confirmed this underwear was used communally for people who needed it. There was no system to make sure that net underwear was not shared between the people who needed it.

The laundry worker also showed us a range of unmarked clothes and they did not know who they belonged to. They reported “it’s a problem we have.” An audit dated December 14, stated “immediate” action was to take place about the issue of unmarked people’s clothing. However the only action was documented as “remind relatives about labelling.” There were no systems to support people who did not have relatives who were able to mark their clothing. There are a wide range of methods available to care homes to support them in ensuring people’s clothes are marked, so they can be returned to the right person. The service had not considered appropriate systems to support people.

People’s dignity, privacy and independence were not supported. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some people did not feel the service was a caring environment, other people made positive comments. One person said “Staff are brilliant, you can’t fault them.” Another described staff as “very caring” and said “They take their time if you need it.” A person’s relative reported staff were “very attentive.” A person said “I use the home as my own, I can go anywhere”. A person admitted for respite care compared the service favourably with others they had been to. They said they had been fully involved in agreeing how staff would support them, and said the care they received mirrored that. A person told us they appreciated the way staff “Always knock on the door before they come in.”

We made a range of observations which showed the caring nature of some staff. A person became upset. The activities

## Is the service caring?

worker took them to their room, for privacy and reassurance. A care worker then came to support the person and remained with them until they felt better. A care worker offered a person a choice whether they would prefer to go back to bed or sit in their easy chair. The care worker was kind and gentle with the person while they made up their mind and did not hurry them in any way. Once they had supported them in what they wanted to do, they asked various questions to check the person was comfortable. A care worker supported a person who was living with dementia, talking to them in a kindly way, checking back with them to confirm they understood what they were saying. At a busy time of day, a person told us they were uncomfortable. We found a care worker, who responded to the person at once, joking in a kindly way with the person, which they clearly enjoyed and responded to in a similar vein.

Some staff respected people's choice and responded effectively to give them the care they needed. A person said they preferred to get up and dressed before breakfast as they found eating at a table was easier than in their bedroom. They were pleased staff supported them in choosing to do this. At lunchtime a person told a care worker their meal was not warm enough. The care worker replaced this with a fresh meal, explaining to us the meal would not taste so good if it was only re-heated in a microwave. We observed a care worker assisting a person to eat their meal, they were very polite, checking the person felt comfortable in a friendly, supportive way while they were assisting them.

# Is the service responsive?

## Our findings

We asked people if they had been involved in drawing up their care plans. We received varied responses. One person said they had never seen their care plan. Another person said "Have never seen it, not involved in it". Other people felt staff responded to their needs. One reported about their care plan "Not seen – staff know what they are doing." A different person said they felt staff had a good understanding of their needs and knew how they liked to live their life. One person told us they knew about their care plan and reported it had been drawn up with them.

The service were not consistently responding to people's individual care and treatment needs. Four of the people we met with had been assessed as being at very high risk of pressure ulceration. One of these people sat out of bed during most of the first day of the inspection. Care workers told us the person was up most days and they encouraged them to get out of bed. We asked care workers how they prevented risk to the person's skin when they were out of bed. Care workers were unable to clearly describe how they did this. We saw the person was sitting in a chair by their bed after lunch. They were not sitting on a pressure relieving cushion. We saw they did not go back to bed until 4:00pm. We asked staff why the person was not sitting on a pressure relieving cushion, but they did not know. There was no information in their care plan about how their pressure areas were to be protected when they were out of bed.

Two of the four people assessed as being at high risk of pressure ulceration were living with diabetes. This meant they would be at high risk of developing pressure ulcers on their heels. None of them had information in their care plans about how their heels were to be protected. Some staff we spoke with were not aware of this additional risk, others were aware, but were not able to tell us about interventions and observations they made to ensure the people did not sustain pressure ulceration to their heels.

The National Institute for Health and Clinical Excellence (NICE) has guidelines which state that pressure ulcers, once developed take an extended period to heal, are painful and may present risk of infection, therefore the emphasis must always be on their prevention. The staff were not following these guidelines.

Most of the people we reviewed in detail had additional needs relating to living with dementia. Care plans about supporting people's dementia were limited and many used generic language which did not inform staff how they were to support individual people.

One person was frail and remained in bed all the time, they needed two members of staff to support them with all their needs. They were not able to converse with us. This person had conflicting information about their dementia in their care plans. One care plan reported they did "not present with behavioural issues," but another documented they did show behavioural needs, including aggressive and restless behaviours. This care plan instructed staff to "to reduce if possible any outburst or signs of aggression." Apart from instructing staff to support the person in a "calm and quiet manner," no other support for the person was documented. The person was prescribed a drug to be taken when required, which could alter their mood. There was no care plan about when or why the medicine needed to be administered. There was also no evaluation of its effectiveness in supporting the person's behaviours. We asked a registered nurse about the prescription but they said they did not know if the medicine had effectively supported the person or not. We asked care workers about the person. They reported they could be physically aggressive at times and each described a variety of different interventions they used to support them. Care workers reported care plans were drawn up by registered nurses, who did not have day to day involvement with supporting the person. They reported as care plans were not coordinated by staff who cared for people every day, they would not know about the effective ways of supporting a person who was living with dementia. The staff were therefore not responding effectively to support people who were living with dementia.

Staff we spoke with reported they had not been trained in caring for people who were living with dementia. The new manager told us they were aware of the need to train staff in dementia awareness but currently other training needed to take priority.

Records were not kept of activities people participated in. There was no analysis of the effect of different activities for individual people, to enable future planning of activities for

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them. Some people did not have information in their care plans about their past lives or activities they wished to participate in, although this was stated to be a key area in the service's statement of purpose.

Other people had care plans relating to activities. Some had not been updated when people's conditions changed. For example we had a fully engaged conversation with a person. Care workers told us the person had made great progress since they had been admitted to the service. They reported the person was interested in being engaged and although they tended to call out frequently, they regarded this as indicative of how much they wanted to be with other people. Staff showed imagination in responding to the person's calling out behaviour, such as doing paperwork near them and taking them to activities. However the person's care assessment stated the person was "very reluctant to socialise and take part in recreational pursuits...unable to hold a rational conversation." This assessment had been drawn up in July 2014, so was now out of date. The person's care plan did not identify or address their calling out behaviour, we which saw was clearly annoying to some other residents. The lack of an effective care plan meant the needs of this person and people were not being addressed.

The issues relating to effective assessment, planning and delivery of care are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people commented favourably on the recreational activities. One person told us enthusiastically "Activities every morning and afternoon," another said activities were "appropriate to the age range." We observed two activities. People were clearly enjoying participating in them. People told us about trips they had been out on. The activities worker reported they took people out by car to cafes or just

for change of scenery. They also had access to local minibuses, including a minibus suitable for wheelchair users. People and staff spoke of the plentiful use of the garden in summer. A person who remained in bed most of the time told us how much they appreciated the views out of the window, particularly being able to watch the sheep grazing in a field close by. The activities worker reported they usually visited people who remained in their rooms every day, partly to discuss menu choices but also to develop conversations with them and invite them to forthcoming events.

We asked people if they knew how to raise concerns and complaints. People confirmed they did. One person said they would "Go and see the home manager". Another person echoed this talking about the new manager by their first name, adding "She would take notice." Another person said they would raise issues with "Any of the nurses." A person reported "They have residents meetings, they listen".

We asked a group of people about residents' meetings. One person said they attended one in December 2014, but that not many others had done so. Another person said they felt comfortable to raise issues in meetings or generally with senior staff, but did not know if comments raised were followed up.

The service's complaints policy was available to people. The new manager had set up clear systems for review and management of complaints reported to them. Since they had taken up their post, they had recorded all complaints they had received, including verbal concerns. Records showed complaints and concerns were considered in detail. The new manager performed full investigations into complaints and communicated their findings to relevant parties. They also apologised to people when complaints had been up-held and explained what they would do in future to improve service provision. People's confidentiality was maintained throughout the complaints process.

# Is the service well-led?

## Our findings

We were given mixed views about the management of the service. One person when asked if they thought the service was well managed said “No I don’t think so if I am honest.” Another person felt the service was “Not well organised.” A person said “I do not feel I am getting value for money.”

Other people gave less negative comments. One person reported “There are a few things I am not happy with.” Another person told us about their mixed views about the service, saying they were aware there had been a change of management which had affected their views. Other people commented on recent changes in management. A person said there had been changes in managers recently and they were “Surprised they had left.” A member of staff referred to previous managers as being inconsistent and described the new manager as “brilliant.” A person said the service was “Very well managed” under the new manager.

The service did not currently have a registered manager. The previous registered manager left after the last inspection in August 2014. The new manager came in post in the Autumn of 2014. They have applied to be registered with us as manager for the service.

The provider had not taken action in relevant areas to follow up on issues raised by people and others. We had been informed by the local authority before the inspection that they had raised concerns about the security of the service on more than one occasion, during 2014. Similar concerns had been raised during residents’ meetings. People also told us during the inspection that they had concerns about security. During the inspection, we found no action had been taken to address these issues. We asked to see the security policy. It did not document relevant actions to be taken in relation to security of the building. There was no action plan about security, despite the issue being raised several times by a range of people.

When people raised issues, the provider did not monitor their own systems to review their effectiveness. People reported on a perception of a slow response when they used their call bell. One person told us “You can ring that little bell and no-one answers it.” Another person said “They don’t come every time.” One of the complaints received had related to a perceived slow response time to

call bells. The service had a computerised, addressable call bell system. No audits of response times to call bells had been undertaken to review these perceptions by people and how they might be addressed.

Some areas of the service were formally monitored, for example medicines management, but actions were not taken when issues were identified. During a spot check on one unit of the service, we noted eight medicines administration records had not been signed, one of which was for an insulin injection. We looked at the medicines audits. The issue of uncompleted medicines records had been noted in every audit up to and including March 2014. The provider had not developed an action plan about how this was to be addressed, to ensure they could verify all people had received their medicines as prescribed.

When issues were audited, the staff did not consider all relevant matters to ensure risk was reduced for people. The accident audit did not consider a range of areas. For example between October and November 2014, over half of the fourteen accidents were documented as happening after lunch and before bedtime. This had not been identified during the quality assurance audit. There was also no audit of where accidents had happened in the building to identify if there were higher risk areas in the service.

Staff did not consistently follow relevant guidelines. This included one person who was self-administering their own medicines. The Nursing and Midwifery Council (NMC) have guidelines for registered nurses on performing risk assessments to ensure people in nursing settings are supported in continuing to give themselves their own medicines. The person’s file did not include any risk assessment in line with the NMC guidelines. We spoke with registered nurses. They did not know why a risk assessment to follow NMC guidelines had not been completed.

The provider did not have effective systems to regularly assess and monitor the quality of service provided and was not identifying and managing risk to people’s health and welfare or always following national guidelines. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a range of records which were not being completed at the time people were supported. When

## Is the service well-led?

records were completed retrospectively, there was a risk of inaccuracies. This meant there might not be correct information available on people's conditions and responses to treatment. We looked at four people's dietary and fluid intake records. They were all completed retrospectively. This included one person's records which at 9:50am showed they had last been completed two days before the inspection. When we reviewed the person's record again at 11:05am, their records for that day and the previous day had been fully completed.

Other records were not being completed to ensure frail people received the support they needed. One person had a bowel care record which had not been completed on two separate periods of six and nine days, during January 2015. We showed the record to a registered nurse, who was unaware of the uncompleted record. The person's medicines record showed they were being treated with a laxative. The registered nurse confirmed this meant the person had a history of issues relating to constipation. The person was not able to communicate verbally or by other means. If they had not opened their bowels for these periods of time, they may have experienced discomfort.

Appropriate action had not been taken when records were not accurate. A person had a record of the weight setting on their pressure relieving mattress which documented the pressure as 50kg. When we checked the mattress at 10:45am the setting on the mattress was 85kg. We checked the record and the mattress setting on two subsequent occasions during the first day of the inspection. The person received care on more than one occasion during this period, but the situation did not change from our observation of 10:45am. The person was very frail and had a history of pressure ulceration. As records were not accurate, the person could have been put at an increased risk of developing pressure ulcers because the mattress was at the incorrect setting.

These issues relating to poor record keeping are a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a statement of purpose which set out the aims of the service, including how these aims would be achieved. The current statement of purpose was out of date because it referred to a range of areas which no longer

applied, including the name of the previous registered manager, regulations relating to previous legislation and an outreach service which the service was no longer involved with.

The statement of purpose emphasised the involvement of people, for example satisfaction surveys. The new manager told us since they came in post they had set up arrangements to conduct a survey, which was now ready to go out to users of the service, visitors and staff. They said they were "looking forward to action planning; we know what is missing but need to know what they see as missing."

The statement of purpose emphasised the importance of staff training. The new manager reported they had identified a wide range of deficits in training since they came into post. They had reviewed staff training needs, established priorities and now had a training action plan which was being worked through.

The statement of purpose did not specifically set out the management structure for the service but all staff we spoke with had a clear understanding about who their line manager was and who they should go to with issues relating to their role. All of the staff we spoke with knew the parameters of the responsibilities for their role. For example, both care workers and registered nurses reported it was the registered nurses' responsibility to apply all prescribed skin creams to people and care workers applied skin creams which related to people's preferences, not a prescription from their GP.

Staff told us internal communications in the service could be improved. There was limited staff email and no paper systems like staff pigeon-holes to communicate relevant information. The deputy manager reported an IT person had visited the service recently to assess staff communication needs.

Some people gave very favourable comments about the service. One person described it as "First class," another that it "Runs like clockwork," and another that they "Can't praise it too highly." One person said warmly "It's a nice place." Two external professionals said they visited the service quite often and did not find any issues relating to it, one describing it as "fine".

Three members of staff said the new manager and their senior team were receptive to their opinions and they felt their views were seen as important and part of solutions.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment  The provider did not take proper steps to ensure each person was protected against the risks of receiving care and treatment which was inappropriate or unsafe. This was because they were not carrying out accurate assessments of people's needs. They were also not planning and delivering care to meet people's individual needs and ensuring their welfare and safety. They did not follow appropriate guidance when providing care and treatment. This corresponded to Regulation 9(1)(a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect  The provider was not making suitable arrangements to ensure the dignity, privacy and independence of people and treat them with consideration and respect. This corresponded to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent  The provider did not have suitable arrangements to obtain and act in accordance with the consent of people, including where best interest decisions needed to be made for people. This corresponded to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

## Action we have told the provider to take

### Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not ensure people were protected against the risks of unsafe or inappropriate care and treatment because there was a lack of proper information about them. They did not maintain an accurate record for each person in relation to their care and treatment. This corresponded to Regulation 20(1)(a)(b)(l) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

### Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider did not ensure staff employed were appropriately supported to enable them to deliver care and treatment to people to an appropriate standard. This was because they did not ensure staff received appropriate training, supervision and appraisal. This corresponded to Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

## Enforcement actions

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

### Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

The provider did not protect people and others who may be at risk from the risks of inappropriate or unsafe care and treatment. This was because it did not have effective systems to enable them to regularly assess and monitor the quality of services provided. Their systems did not identify, assess and manage risks relating to the health, welfare and safety of people and others. The provider was not making changes in their service provision having regard to information contained in records, following appropriate expert advice and reports from the Commission. Regulation 10(1)(a)(b)(2)(b)(iv)(v)(c)(i)(ii)

#### The enforcement action we took:

A warning notice has been issued. The service is to be complaint within three months of receipt of the warning notice.

### Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

The provider was not protecting people against the risks associated with unsafe use and management of medicines. This was because they did not have appropriate arrangements for recording, handling, safe-keeping, dispensing and disposal of medicines. Regulation 13

#### The enforcement action we took:

A warning notice has been issued. The service is to be complaint within three months of receipt of the warning notice.