HC-One Limited

Meadow Bank House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 April 2018 and was unannounced. Meadow Bank House is registered to provide personal care and nursing for 47 people. On the day of our inspection there were 41 people living at the home. The home is a purpose built care home in the Great Lever area of Bolton. There is limited outside space and some people would need accompanying to sit outside safely. Car parking is available at the front of the home. The home is close to local amenities and is on a main bus route.

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

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

At our last inspection in September 2015, we rated the service as good. At this inspection we found that the service had deteriorated and was in breach of five regulations. This was because people living at the home did not receive appropriate care and treatment; were not provided with sufficient activities; their dignity was not always maintained; and were not safe in relation to health, safety and welfare. We also found that records were not accurate and the staffing levels were not always sufficient.

We asked people if they knew who the registered manager was in case they wished to speak with her. One person said, "I don't think I have seen her, she's very busy". Another said, "Yes she does a good job". A third person told us, "I've seen her but she doesn't come round everyday". A relative said, "The manager comes to see her [person who used the service]".

Some staff told us they felt they could be better supported by the management team and that they did not always feel they were listened to and any concerns they raised were not taken seriously.

We asked people if they thought the home was well run. Comments included: "They [staff] are trying their best". Another said, "It's alright, it would be good if they had a few more carers".

We looked at the Key Clinical Indicators Summary for February 2018. We were told this was an audit that was undertaken monthly. The document identified such things as; incidence of pressure ulcers, weight loss, falls, use of bedrails and infections. We were told the audit helped the registered manager and senior management to assess the safety and quality of their service.

We saw that the service was meant to ensure regular checks and audits were carried out. However, the audits were ineffective or inadequate as they had failed to pick up the concerns found during the inspection.

Three care records showed there were gaps of several months between reviews of the risk assessments. For one person the mattress checklist should be have been completed daily by the day and night staff. This was to ensure that the bed setting was correct for the individual. We only saw three dates of checking, namely, 30 and 31 of March and 1 April 2018 were recorded. This meant that the checks had not been carried out as required and the provider could not be assured that the mattress setting was correct, posing a risk to the person using i.e. found gaps in some of the weekly /monthly checks. For example, on one record of daily tasks to be completed we saw this had not been completed since 27 March 2018. The weekly checking of fire extinguishers and fire blankets had not been completed since 2 January 2018.

We saw that certificates were in place for the maintenance of the gas and electrical testing, testing of small electrical appliances (PAT), water testing, lifts and hoists. There was a contingency plan in place in the event of utility failure.

Processes were in place to listen to residents, relatives and staff, and respond appropriately. An annual resident / relative survey was completed. Resident / relative meetings every month and the day and time of the meeting was alternated to accommodate all those wishing to attend. There was have a voice survey tablet situated at in the reception area of the home, which is accessible to all residents, relatives and visiting professionals.

The register manager attended the care home and provider meetings. The home had recently applied for and had successfully secured funding from the council transformation fund. We were told this money was to be used for sensory material on both floors and a new diner with a 1950s theme was planned.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Most of the people we spoke with said they felt safe living at the home. There were some negative comments raised about the kindness of some of the night staff.

Medicines were not given safely .Medicines which needed to be given at specific time with regard to food were not always given at the correct times.

Fire safety required reviewing to ensure that people remained safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not receive person centred care that met their needs and preferences. Some people were not receiving appropriate care and treatment.

The service was working within the legal requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy, dignity and independence was comprised. People's diverse needs were not always addressed.

Some people spoken with questioned the kindness of some of the staff.

There was a service user guide available that provided information about the home and the services available.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People spoken with told us activities were limited. There was no evidence of activities on the day of the inspection.

Care records contained some guidance for staff on how people were to be supported and cared for. We saw however that there was not always enough information to ensure people's needs would be met.

Staff had received training in caring for people who were nearing the end of their life.

Systems were in place to receive and respond to complaints. The service had received a number of compliments.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

Systems were in place for completing regular audits and checks. However the audits had failed to identify gaps and areas of concern.

We were told that the registered manager's presence was not always visible. Some people spoken with did know who the registered manager was.

The registered manager attended local care home meetings and worked closely with other agencies.

Meadow Bank House

Detailed findings

Background to this inspection

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

The inspection was prompted in part by a number of whistleblowing notifications. Identified areas of concern included: lack of night staff, no time for staff to offer showers and baths and people not being repositioned whilst in bed. The local authority safeguarding team had been notified of the concerns and had visited the home. Due to the concerns raised we started our inspection at 6.15 am. This gave us the opportunity to see the early morning routine and speak with the night staff.

The inspection team consisted of two adult social care inspectors, a medicines inspector and 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.

Prior to our inspection we looked at the information we held about the service, this included the last inspection report, safeguarding and whistleblowing information and statutory notifications. We also received a copy of a provider information return (PIR) form. A PIR asks the provider to give us some key information about what the service does well and what improvements they plan to make.

Before our inspection we contacted Bolton local authority commissioning team, the local authority safeguarding team and a healthcare professional. We contacted Healthwatch Bolton to see if they had any information about the service. Healthwatch England is the national consumer champion in health and care. This was to gain their views on the care delivered by the service.

During our inspection we spoke with the registered manager, the area director, 10 members of staff, 13 people who used the service, two relatives, the cook and domestic staff. We looked at four care records, seven personal care charts and 20 medication administration records (MARs). We also looked at four staff files, staff supervisions and audits. We requested that the training plan to be emailed by 4 April 2018. This was not received.

Inadequate

Is the service safe?

Our findings

We asked people what made them feel safe. One person told us, "At night they have carers that come round, but the night carers are more nasty, they don't like it when you press the buzzer, the man shouts. I don't want to make trouble because they get back at you. If you call them they make you wait." This person went on to describe the undignified position they were in if they had to wait too long, meaning they were left in wet, soiled clothing. Another person said, "Sometimes they pull me about at night. I have complained and it got a bit better". However, in contrast, another person said, "They [staff] have been alright with me; there's no reason not to feel safe". One relative spoken with could not fault the service and told us their relative was safe and well cared for.

Inspection of staffing rosters showed that the home operated on the following staffing levels; On Poppy Unit, the nursing unit, for the 19 people who used the service, there was one registered nurse and four care assistants on duty between the hours of 8am and 2pm and from 2pm to 8pm one registered nurse and three care assistants. During the night time hours there was one registered nurse and two care assistants. From our observations, a review of care records and a discussion with staff we were made aware that the majority of the people on Poppy Unit had high dependency care needs and required the assistance of two carers.

On Primrose, the residential unit, for the 21 people who used the service, there were four care assistants on duty between the hours of 8am and 8pm and two care assistants on duty throughout the night time hours. Although we saw there was an assessment tool in place to determine the dependency needs of people, it did not identify the number of staff needed to ensure people's needs would be met.

Staff spoken with said there were not enough staff to cover, especially at night. They could not complete the tasks they were meant to do. Information received from a whistle-blower said, that they were worried about staffing levels especially at night and people were not being washed properly.

Apart from their regular caring duties we saw a list of tasks that night staff were also expected to complete. For example, on a Sunday night staff had to clean hand rails, brush and mop the lounge and dining room , clean the crash mats, stock the linen trolley for the day shift, wipe down chairs in the lounge and dining room and change the papers over in the care records.

From our observations the cleaning tasks for Monday 2 April 2018 had not been completed as staff had not enough time. We brought to the attention of the registered manager that a number of crash mats in people's bedrooms were dirty and needed cleaning. Crash mats were placed at the side of some people's beds to help prevent injury should they roll out of bed.

We found that the service was failing to have sufficient staff at all times to meet people's needs was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During our walk around the home we found that flammable furniture was being stored under the ground floor stairwell. This posed a fire risk. In addition, the area at the top of the stairs, which is a fire escape, was

obstructed with furniture. The obstruction of the fire escape placed the health and safety of the people who lived, worked and visited the home at risk of harm.

We saw that the home had an emergency evacuation folder at the front door. Each person had a personal emergency evacuation plan (PEEP) in place. A PEEP informs the fire service of what assistance each person requires to safely evacuate them in the event of fire. For example, the use of wheel chair or mattress for evacuation. We noted that the front sheet stated that 45 people were living in the home and nine day and five night staff were on duty. We discussed with the registered manager that this information was incorrect and would be misleading for the emergency services who could possibly be looking for more people than the record showed in the event of fire.

Following our inspection we contacted the Greater Manchester Fire and Rescue Service with our concerns. The fire safety officer visited the home on 4 May 2018 and found that some of the fire doors required maintenance. On arrival at the home staff were around the fire alarm panel as this had activated. The fire officer saw staff were struggling to reset the alarm. The fire officer could not confirm whether staff had just assumed it was the workmen setting this off, rather than investigating which head had activated. The fire officer was to return to the home to discuss his findings with the registered manager. The fire officer confirmed that he contacted the registered manager to discuss his findings and had issued a Notification of Deficiencies (Advisory letter). Within the letter comments included: keeping the corridors clear. Advice was given about confirming means of escape from the staff area (the green break glass point appeared to be on the wrong side of the door). Staff training due to what he had witnessed with fire alarm during his visit on 4 May 2018 and some room doors which required maintenance.

We found this was a breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that windows above ground floor level were fitted with restrictors to prevent people falling out of them. We saw that the central heating radiators in communal areas and bedrooms were covered to prevent injury to people. We did note however that one person had their bed placed next to a covered radiator that was hot. Following the inspection we were told that the bed had been moved away from the radiator to ensure the safety of the person who used the service.

We noted that the home was having internal work done; therefore it was difficult to keep carpets clean. New flooring was ordered. However, in the upstairs lounge/dining room we noted that food and dust had been swept against the skirting board. This was noted first thing in the morning and was not removed until late afternoon. This was also brought to the registered manager's attention. The infection control audit of 26 February 2018 stated that attention was needed to flooring edges and corners and that these needed adding to cleaning schedule.

We saw staff wore protective clothing of disposable gloves and aprons when carrying out personal care duties. Alcohol hand-gels and hand-wash sinks with liquid soap and paper towels were available throughout the home. Good hand hygiene helps prevent the spread of infection and wearing protective clothing helps protect staff and people who use the service from the risk of cross infection during the delivery of care. However, we noted that some staff had long and painted nails, which pose a risk of injury and/or cross infection.

The Specialist Nurse-Community Infection Prevention and Control Team completed an audit on 26 February 2018 with an overall score of 73%. This was lower than the previous audit score last year of 88%. It was noted that a different standard of cleanliness was found between ground (nursing) and first floor

(residential). This was discussed with the registered manager at time of audit. The specialist nurse is to audit the home again within three to six months of months of their last visit.

We looked at the on-site laundry facilities situated on the top floor. We found there was sufficient laundry equipment to ensure effective laundering. Hand-washing facilities and protective clothing of gloves and aprons were in place and specialised bags were used for heavily soiled laundry.

The four care records we looked at showed that risk assessments had been completed to identify any potential risk of accidents and harm to staff and people in their care. We saw that, to help reduce or eliminate the identified risks, such as poor nutrition, falls and the risk of developing pressure ulcers, care plans had been put into place following the initial assessments. One of the care records showed however that the falls risk assessment had not been reviewed for 12 months. There were no records available for this risk assessment since April 2017.

The care record of another person identified on 3 February 2018 that they were at high risk of developing a pressure ulcer. Despite the high risk, no further risk assessment had been undertaken.

Risk assessments relating to the health, safety and welfare of people who use the service must be reviewed regularly to ensure their changing needs are met. We found this was a breach of Regulation 12(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The other three care records showed there were gaps of several months between reviews of the risk assessments. It was explained to us that the gaps were because those records had been archived. Whilst we were satisfied with the explanation, we did discuss with the registered manager the need to ensure that all the records were still available or a summary of the information was retained on file. This was because the gaps between the risk assessment reviews gave the misleading impression that the reviews had not been undertaken. We saw that from the month of February 2018 onwards risk assessments were reviewed monthly.

Records showed that any accidents and incidents that occurred were appropriately recorded. The registered manager told us that accidents and incidents were recorded and reviewed regularly. Monitoring accidents and incidents can assist management to recognise any recurring themes and then take appropriate action; helping to ensure people are kept safe.

During our inspection we saw that medicines were not stored safely. We found that the trolley was open, unlocked and unattended for over five minutes which meant that people had access to medication which is unsafe. After the inspection we were informed that the nurse had left the trolley to assist someone in difficulty and they thought the trolley was locked. The medication room was accessible by a keypad and it was therefore accessible to any people who had the code. Only staff trained in medicines handling should have access to the medicines room. After the inspection we were informed that a lock had been fitted so that only permitted people had access to the room. We found fridge temperatures had not been recorded daily and that when the temperatures had been recorded they were out of the safe range for the storage of medicines. This meant that medicines stored in the fridge had not been stored at the correct temperature and may not work properly. We also found that waste medicines were not stored safely, according to NICE guidelines waste medicines must be kept in a locked cupboard at all times. However we found the medicines waste was not locked away.

Medicines were not given safely. Medicines which needed to be given at specific time with regard to before food were not always given at the correct times. This meant that those medicines may not work properly

placing people's health at risk of harm. We saw that people who were prescribed Paracetamol were at risk of being given doses too close together because staff failed to record the time of administration of each dose. We saw that when staff applied medicines in patch form they did not always record the site they had last applied the patch to, so it was not possible to rotate the sites as directed by the manufacturers. One person was prescribed a patch that must not be applied to the exact same skin location for 14 days to avoid the risk of skin irritation. The staff failed to do this because they were unaware of the manufacturer's directions.

When people were prescribed insulin their blood sugars must be monitored. We found staff were monitoring the blood sugar levels but had not recorded the safe range of levels that applied to each individual. Therefore it was possible that insulin was not always being given safely.

We saw that one person had been prescribed an increasing dose of their medication. The instructions, from the prescriber, of how to increase the dose were not clear. However staff failed to clarify with the prescriber how the dose should be increased. This failure resulted in the dose not being incrementally increased properly. The staff had not put any pain monitoring procedures in place which meant they could not effectively assess the pain levels of this person. It was only the intervention of the medicines inspector during the inspection that prompted the nurse to check with the doctor. We also saw that one person was prescribed one tablet to be given four times daily. However, we saw it was recorded that for approximately half the doses given they were given two tablets which was double the prescribed dose. This could place that person's health at risk of harm. Another person was prescribed two tablets to be taken but on four occasions the records showed that only one tablet had been given without any rationale recorded as to why a different dose to the prescribed dose had been given.

We found that when people were prescribed medicines to be given "when required" the information recorded to guide staff how to administer medicines prescribed in this way was either not available at all or had minimal personalised information. We also saw there was no guidance available for staff to follow when medicines were prescribed with a choice of dose and staff failed to record the rationale for giving the higher or lower doses to people. This meant that people prescribed medicines in this way were at risk of not being given them safely, effectively or consistently.

Some people were prescribed a thickening agent to be added to their fluids, due to them being at risk of choking whilst drinking. We saw that the directions for the number of scoops of powder to be added to drinks was not always correct, which placed people's health at risk.

We looked at the records about the application of creams and found these were not always completed accurately or in some instances no records were kept at all. Some information about where and how often to apply creams was missing. Which meant people may not be having their creams applied when and where they need them.

We saw that people did not always have their medicines as prescribed because the records showed there was no stock. One person complained that they had not had their pain cream applied because staff were unable to find it and that they were in pain. The records confirmed that none was recorded as being in stock.

We saw that there were items on the medicines administration charts which had not been signed as given because no stock had been recorded as received. There was no information to show these items were no longer prescribed, which indicated that people had missed doses of their medicines because the medicines were out of stock. We also found that thickeners for some people had run out and they were using other people's thickeners to make sure drinks were still thickened. However, not everyone was prescribed the

same brand which meant by "borrowing "thickeners from other people they may not be given the correct consistency of drink.

During the inspection we did a spot check on stock levels of a number of medicines and found that some medicines could not always be accounted for. These stock checks also showed that some medicines had been signed for but not given.

The records about medicines were not always accurate. Records showed for one person they had been given double the dose of one of their prescribed medicines because that medicine had been printed on the medicine administration record (MAR) twice. Staff had failed to notice this and had not deleted the duplicated entry, but had signed they had given it on both occasions. The staff used some codes incorrectly which meant it was difficult to tell why medicines had not been taken.

We saw that the service ensured regular checks; audits for medicines had been done. However, these were ineffective as they failed to pick up the concerns found during the inspection.

We found this was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four staff personnel files and saw that staff recruitment was robust. Each file included a photograph, application form, proof of identity, two references and terms and conditions of employment. All potential employees had a Disclosure and Barring Services (DBS) check in place. A DBS check helps ensure people are suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Whilst walking around the home during the early morning of the inspection we saw that one person had both their feet out of bed. We saw that the person had a large wound on the top of each foot; one of the wounds was open and oozing fluid and the other wound was very dry and lifting slightly at the edges.

We spoke with the registered nurse about our concerns that the open wound had not been dressed and that the dried wound was at risk of being 'lifted', especially if there was friction from the bedclothes or from the person's other leg. The registered nurse attended to the wounds later in the day. We discussed this with the registered manager and the area director who agreed a swab needed to be taken and sent for examination. We spoke with the Specialist Nurse from the Community Infection Prevention and Control Team on 18 April 2018. They confirmed that no swabs been taken since July 2017 at this service.

Following the inspection the area director informed us on 10 April 2018 that dressings and cream were available for the wounds and that an investigation into why the wounds were not dressed had commenced. These omissions should have been highlighted in audits of pressure wound management.

The provider had failed to ensure that this person had received appropriate care and treatment. We found this was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personal cleansing charts for seven people. We were told that staff must document on these charts when people have had a bath or a shower. The charts identified that from 1 March 2018 six of the seven people had not had a bath or a shower. One person had been given one bath only. One person told us, "I requested a shower on Wednesday (28 March 2018) and was told I would have to wait until Saturday. A person was very poorly so I could not have my shower. I am still waiting".

We discussed our concerns about the lack of personal cleanliness with the registered manager who informed us that they felt sure people had been bathed or showered and that the records were not correct. Following the inspection the regional manager informed us that there was evidence to suggest that this was due to inaccurate documentation rather than a lack of personal care.
Failing to have an accurate complete record of the care provided is a breach of Regulation 17 (2)(c) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked if the staff received a report on each shift change to ensure that all staff were made aware of each person's well-being and condition. The registered nurse in charge of Poppy Unit told us that in addition to the daily/ night record that was written there was also the 'resident handover sheet' that was written by the nurse on the previous shift. The handover sheet contained basic information of any changes that had occurred.

We saw on the day of our inspection staff were arriving at 7.45am; this was so they could attend a handover session. However, staff were observed clocking in and then going outside for a cigarette. We discussed this

with the registered manager. On speaking with staff there were some discrepancies as to what time they were paid from in a morning. However, we noted that a staff memorandum had been sent to staff on 28 March 2018 about starting the day shift. It stated, "Please can all staff be starting work at 7.45 for their daily handover. This is a very important stage of your shift, this gives you the information you need to carry out your daily work". No detailed handover was given to the care staff. The senior carer on nights on the ground floor gave a less than five minute handover to the day staff. However, the night staff were working past the end of their shift.

We looked to see how the staff at the home worked in cooperation with external healthcare professionals to ensure that people using the service received appropriate care and treatment. The care records showed that people had access to professionals, such as GPs, specialist and community nurses, opticians and chiropodists.

We asked the registered nurse to tell us how, in the event of a person being transferred to hospital, information about the person was passed to the receiving service. We were shown the 'Red Bag' that was sent with the person. The Red Bag Initiative was rolled out to all nursing homes across Bolton NHS Foundation Trust. It aims to improve the experience of people when they are admitted to hospital. The Red Bag should contain the person's care and medication records, their medication and their personal items.

We looked at the kitchen and food storage areas and saw good stocks of fresh, frozen and dry foods were available. We looked at the menus and saw they were on a four week cycle and a choice of meal was always available.

The menus were displayed outside the dining room. We saw the lunch time meal displayed was served at teatime and the teatime meal was served at lunch time. This was confusing for people. We asked the registered manager why the menus were not written to reflect what choices people were being offered. The registered manager confirmed these could not be amended at the home; they had to be done at head office. We did not see any evidence of pictorial menus to assist people living with dementia to make choices. We received mixed responses about the food served. One person told us, "The food is very nice". Another said, "We have a lot of sandwiches". Another person told us that their cultural needs with regard to diet were not catered for and that their family brought food in for them. We observed that drinks were being served mid-morning and afternoon and at meal times.

Due to the work at the home it was not possible to assess the overall dining experiences for people. We saw that staff assisted people with their meals as required.

A discussion with the cook showed they were knowledgeable about any special diets that people needed. We saw that plate guards were available for people who needed additional aids to keep their food on their plate. However, we were told there was no adapted cutlery in the building; necessary to help maximise people's safety independence and dignity whilst eating their meals. This would have to be ordered in for people if required which may take some time.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Consent forms for photos, access to records and assistance with care were completed appropriately, either signed by the person who used the service or their representative, where appropriate. Staff spoken with had limited knowledge of MCA and DoLS. One person said, "We have covered it on eLearning but I don't like that type of training, I prefer face to face, I think you take it in better". Other staff spoken with said they had a 'rough idea' of which people were subject to DoLS but were not aware of any conditions.

The action plan provided on 10 April 2018 stated that all staff had received training on MCA and DoLS. However, this had been reassigned to all staff and would be reviewed in staff meetings and supervisions. Staff spoken with said they had received someone to one supervision meetings with the registered manager. One to one meetings provided staff with the opportunity to discuss any worries or concerns they may have and to talk about any further training and development they may wish to undertake. We discussed with the registered manager that some of the supervisions were all of the same theme. The action plan received from the area director on 10 April 2018 stated that, "Supervisions had been completed. However, they focussed on specific issues rather than a general one to one. The home manager was to be instructed on what is expected in respect of supervisions and appraisals. A supervision matrix was to be implemented to plan one to one sessions and to document those that had been completed.

Staff confirmed that they were expected to do eLearning training at home in their own time or they could come into the home on their day off and get paid for completed training. Staff confirmed they had completed moving people safely; this also included a practical session. Staff said they had completed eLearning fire training and been involved in a fire drill. However they said they had not received practical fire training. Dementia training had also been completed on eLearning. During our inspection we asked the registered manager to email the staff training plan. We did not receive this information. Therefore we are unsure of what training had been provided. Staff spoken with told us there was a thorough induction in place for new staff on commencing work at the home. Without the evidence of the training plan we cannot be sure that staff were properly trained and able to do their jobs effectively.

Requires Improvement

Is the service caring?

Our findings

On arrival at the home we saw that people were being woken up by the night staff. We were told that they had been instructed to 'start washes' and get people dressed from 6am. Staff on the ground floor told us they were expected to have everyone on their floor washed and dressed before the day staff came on duty. No drinks or refreshments were available until 9am when breakfast was served. Staff said they had not had time to make them. We discussed this with the registered manager who was unaware this practice took place.

During the early morning of the inspection we were made aware that a person who used the service wanted to use the toilet to pass urine. We overheard the registered nurse say, "You have your pad. No need for toilet." The two care assistants on duty at that time told us the person was at risk of falling off the commode so was told to pass urine in their continence pad.

An inspection of this person's care record showed they, 'required hoisting onto the commode by two staff.' It was also documented in the care record '[Person who used the Service] will tell staff if they need the toilet". We spoke with the person who used the service who told us they did not like having to pass urine in their continence pad and preferred to use the toilet. This was degrading and unacceptable.

Another person told us, "Sometimes I have accidents during the day waiting to go for a wee. When they are short of staff you have to wait." A third person said, "They could do with more staff. You have short notice on your bowels and they have to go to other people so I have an accident, it makes me upset". A fourth person told us, "I asked at night to go on the commode, they said no, do it in the bed. I am not used to that kind of life. I wear a pad in the day and I have to wee in the pad. It's not nice I am better on the commode".

The practice of requiring people to urinate in their continence pads does not respect their dignity. We found this was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the early morning of the inspection we saw on Poppy Unit that every bedroom door was left open during the night. In addition the door to some of the en-suites were partially opened to shield the light from the corridor coming into the room. We discussed this with the night staff who told us, it was so they could hear what was going on at the other end of the corridor. People's preferences had not been taken in to account as to whether they found the light disturbing.

The home operated a key worker system. This is where staff checked if people rooms were safe, clean and wardrobes and drawers were tidy. The night staff were expected to carry out these roles during their shift. This meant going in to people's room to carry out these tasks when people were sleeping. This was inappropriate as people's sleep could be disturbed and their privacy compromised.

On arriving at the home, it was still dark outside. The lights were on in the home. People from outside could see in to the dining room and down the corridors. People could clearly be seen from outside. Consideration

should be given to making the home more private.

One person told us they wanted a blind at their window as their room overlooked the car park. Staff would have to close the curtains when personal care was provided as people could see in to the room. The sun also shone in to the room preventing them watching the television without closing the curtains. The room also required attention to the décor as the room had two windows that overlooked the corridor. These had been boarded over but had not been painted. In the same room we tested the hot water in the hand basin at the request of the person whose room it was. There was a problem with the hot water and this person would not be able to wash independently as the water was cold. We discussed this with the registered manager and the maintenance man who said there was a problem with the hot water in the hand basin. We asked for this to be rectified as soon as possible.

We saw that bathrooms, toilets and bedrooms had over-riding door locks. This was to ensure that people's safety was considered whilst respecting their privacy and dignity.

We saw a member of staff offer a person a drink. The member of staff served the drink in a plastic cup with a lid and spout. This person told the member of staff, "You have done it again, put my drink in one of those cups; I don't want it in one of those". The drink was then transferred to an ordinary cup which this person managed without any problem.

We saw a large white board in the staff office that contained confidential information about people who used the service. This information was visible to people if they visited the office. This meant the information was not kept confidential. Although people's names were not used, their room number was. Following the inspection the regional manager informed us that steps had been taken to cover the board with a roller blind.

We saw that the home was providing care for people from different ethnic backgrounds. One person told us that the food did not meet their cultural needs and that their family had to bring food in for them. This person went on the say the food was not good and that they were given lots of sandwiches.

There was a resident's guide available to people wishing to move into the home and for their families to refer to. This provided information about personal property, personal finances, and additional services such as chiropody, optician and the dentist. Information also included hospital visits, medication and participation in home life. People could also access a Statement of Purpose if required.

Requires Improvement

Is the service responsive?

Our findings

The care records we looked at showed that assessments were undertaken prior to a person being admitted to the home. This was to ensure their identified needs could be met.

We looked at four care records. The care records contained some guidance for staff on how people were to be supported and cared for. However there was insufficient information to guarantee people's needs would be met.

We looked at the care record of a person with a wound on each foot, both in need of care and treatment. We saw that information in the body map record identified that on the 20 January 2018 the wounds were 'Dry and scaly but intact.' There was no further information in the care record about the condition or care of the wounds. There was also no information in the 'Wound Care File' to indicate any changes of condition to this person needs.

A further three care records we looked at showed that the people had previously developed pressure ulcers. There was no evidence in the care records to show the progression of the ulcers; whether they had deteriorated, improved or healed. The registered manager told us that all the pressure ulcers had healed and that the records had been archived. It was not possible however, from the care notes available to determine if they had.

It was documented on the body map that one person had a pressure ulcer in February 2018. There was no further information on that body map to show if the pressure ulcer had healed.

It was documented on a wound management chart that another person had wounds to their head in December 2017. There was no further information on that wound management chart to show if the wounds had healed.

The third care record showed that the person had a pressure ulcer in October 2017. There was no information on that record to show if the pressure ulcer had healed.
We discussed with the registered manager the need to ensure that, whilst it is good practice to archive records no longer required, the records still in use need to clearly show that the previously identified wounds had healed.

One person, who due to a medical condition, was fed artificially through a tube in their stomach, was to have no food or fluid by mouth. This meant their mouth could become dry and sore with the possibility of an infection developing. There was no care plan in place for the care of their mouth. A discussion with staff showed that even though there was no mouth care plan, mouth care was given regularly as staff, 'know it has to be done.'

The care record of another person showed they were to have their blood taken at regular intervals each day to check their blood glucose levels. If a person's blood glucose level is too low or too high their insulin dose

may need to be withheld/ reduced or increased to maintain their well-being. Medical or specialist advice may also need to be sought. There was no information in the person's care record to show what the maximum and minimum range of their individual glucose levels should be. Not having this information in place could affect the health and welfare of the person who used the service.

We found the lack of accurate care and treatment plans was a breach of Regulation 9(3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plan of one person showed there were gaps of several months between the reviews of the care plan. It was explained to us that the gaps were because the previous reviews had been archived. We saw that from the month of February 2018 onwards the care plan had been reviewed monthly. We asked the registered manager to tell us how staff cared for people who were very ill and at the end of their life. We were told the registered nurses were experienced at caring for people nearing the end of their life and that the staff at the home received good support from GPs, the local hospice and the MacMillan Nurses where appropriate. We were told by the area director on the action plan received on 10 April 2018 that end of life training had previously been provided for some staff. All staff were to have training reassigned to them and this was to be completed by all staff with three months.

We saw that information was easily accessible and visible in a person's care record when they had a Do Not Attempt Resuscitation (DNAR) in place. This is a legal document that identifies that an informed decision has been taken to withhold cardiopulmonary resuscitation (CPR).

We asked how people spent their day. One person told us, "One or two of us play dominoes and bingo or we watch a film. We did have a singer in a couple of weeks ago". Another person said, "I have a shower once a week and the hairdresser on a Wednesday, I play dominoes but I don't do anything else". A third person told us, "I watch television, I sit here all day. I am frightened of asking to go out". A fourth person said, "Sometimes I lie in bed and watch television, sometimes I get up. I don't think I have seen any activities".

On the day of the inspection we saw no evidence of activities taking place. The action plan received on 10 April 2018 stated, "There is not a lack of activities in the home as evidenced by the information that has been provided after the inspection." No information had been provided to the inspector as suggested. The action plan stated, "The activity coordinator was on leave at the time of the inspection and therefore no activities were provided on that day". There should have been staff available to offer a range of activities to people who used the service. If this was planned leave alternative arrangements should have been factored in. It was unacceptable to leave people with nothing to do all day because of staff absence.

We saw that systems were in place to receive, handle and respond to concerns and complaints. The service had received a number of compliments cards from families. Comments included, "I cannot praise each and every one of your staff. We were made more that welcome, we felt comfortable and all the staff treated us with respect". "To all staff, just to say thank you doesn't seem enough but we hope you know how much your thoughtfulness has meant to us".

Requires Improvement

Is the service well-led?

Our findings

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

We asked people if they knew who the registered manager was in case they wished to speak with her. One person said, "I don't think I have seen her, she's very busy". Another said, "Yes she does a good job". A third person told us, "I've seen her but she doesn't come round everyday". A relative said, "The manager comes to see her [person who used the service]".

Some staff told us they felt they could be better supported by the management and that they did not always feel they were listened to and any concerns they raised were not taken seriously.

We asked people if they thought the home was well run. Comments included: "They [staff] are trying their best". Another said, "It's alright, it would be good if they had a few more carers".

We looked at the Key Clinical Indicators Summary for February 2018. We were told this was an audit that was undertaken monthly. The document identified such things as; the number of people, who had pressure ulcers, weight loss, falls, had the use of bedrails and had infections. We were told the audit helped the registered manager and senior management to assess the safety and quality of their service.

We saw that the service was meant to ensure regular checks, audits, for medicines had been done however they failed to pick up the concerns found during the inspection. This called the quality of the auditing into question.

Three care records showed there were gaps of several months between reviews of the risk assessments. For one person the mattress checklist should be have been completed daily by the day and night staff. This was to ensure that the bed setting was correct for the individual. We only saw three dates of checking, 30 and 31 of March and 1 April 2018 were recorded. This meant that the checks had not been overseen by management and could have been detrimental to this person's wellbeing.

We found gaps in some of the weekly /monthly checks. For example on one record of daily tasks to be completed we saw this had not been completed since 27 March 2018. The weekly checking of fire extinguishers and fire blankets had not been completed since 2 January 2018.
Failing to have an accurate complete and accurate audits is a breach of Regulation 17 (2)(b) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that certificates were in place for the maintenance of the gas and electrical testing, testing of small electrical appliances (PAT), water testing, lifts and hoists. There was a contingency plan in place in the event of utility failure.

Processes were in place to listen to residents, relatives and staff, and respond appropriately. An annual resident / relative survey was completed. Resident / relative meetings every month and the day and time of the meeting was alternated to accommodate all those wishing to attend. There was have a voice survey tablet situated at in the reception area of the home, which is accessible to all residents, relatives and visiting professionals.

The register manager attended the care home and provider meetings. The home had recently applied for and had successfully secured funding from the council transformation fund. We were told this money was to be used for sensory material on both floors and a new diner with a 1950s theme was planned.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found that people living at the home did not receive appropriate care and treatment. People were not provided with sufficient activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect We found that people's dignity was not maintained at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that people living at the home were not safe in relation to health, safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found that you failed to complete accurate records of care and audits were not effective

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the service was failing to have sufficient staff at all times to meet people's

needs.