Mr & Mrs K Kowlessur

Broad Acres

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

Summary of findings

Overall summary

This inspection took place on 3 and 4 April 2017 and was unannounced. At the last inspection on 2 February 2016, we asked the provider to take action to make improvements to the signage and decoration in the service, record keeping and the assessing and how they assessed and monitored the quality of the service. We received an action plan from the provider stating they would meet the relevant legal requirements by 31 May 2016. At this inspection we found that they were still in breach of some regulations. At this inspection we found that although some minor improvements had been made the service still needed to improve further and in some areas had deteriorated.

The service provided nursing care and support for up to 48 people some of whom have mental health needs and others who may be living with dementia. On the days of our inspection there were 34 people living in the service.

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

The decoration within the service did not always support the needs of people living with dementia and in some instances was not safe. Quality assurance processes had not identified deficiencies in people's care plans or shortfalls in the quality of the service provided.

The service did not keep up to date with national safety alerts issued by government. A serious incident had occurred, the circumstances of which had been addressed by an alert. In another case there was no evidence to confirm the service was following safe mouth care practice when an alert had been issued regarding this. People were being placed at an ongoing risk.

Staff did not receive the necessary competency checks. Nurses who had carried out training had not had their competency checked. The registered manager who was also the clinical lead was not aware of their responsibilities in this regard. Therefore people were placed at potential risk of receiving unsafe care and treatment from nurses. Safeguarding training was inadequate to meet the needs of staff as it consisted of a handout and a questions and answers sheet. The service had not introduced the Care Certificate for care staff and therefore the quality of care offered was not as it should be.

An incident which was a safeguarding concern and which was a disciplinary matter had not been recognised as such, reported to the correct authorities or investigated thoroughly. People were not effectively protected from possible harm.

People did not always have their choices and preferences met in how they lived their daily lives. These were

not recorded in their care plan and staff did not demonstrate an understanding of the Mental Capacity Act when providing care and support.

Whilst some care staff were observed to provide care and support with kindness and compassion others did not. The approach to care was not consistent and there was no routine monitoring of staff practice to address this. We saw a reliance on staff who were intuitively good carers but no actions in place to support and improve others practice.

Nursing care and clinical governance was poor. The management of pressure ulcers and catheters did not reach required standards. Pressure relieving equipment was not set to the appropriate levels. People were placed at ongoing risk of developing sore skin and not receiving effective treatment for the pressure ulcers they had sustained.

People were not supported with their social needs. The only organised activities observed during the two days of our inspection was a game of skittles.

The leadership of the service was poor. The service quality assurance processes were not used to drive improvement and had not independently recognised the issues raised in this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service did not follow national safety alerts.

The decoration and furnishing of the building was not managed to keep people safe.

Medicines were not stored and managed safely.

The service did not follow clear disciplinary procedures to ensure staff provided safe care and treatment.

Is the service effective?

Inadequate

The service was not effective.

Nursing and care staff did not receive appropriate competency checks to provide care based on best practice.

The design, adaption and decoration of the service did not always meet people's needs.

People were not supported to enjoy their meal and not everybody enjoyed the food.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always demonstrate caring compassionate behaviour.

People did not always have their support provided as they preferred.

The display of personal information within the service did not respect people's dignity

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not adequately guide staff on the care and support to be provided and action to be taken.

Where equipment was used to support people's needs this was not used effectively.

Relevant activities were not provided and people who remained in their bed rooms were in danger of becoming socially isolated.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance audits did not identify shortfalls in the quality of the service.

The service did not keep always up to date with clinical governance best practice.

Improvements identified as being required at our previous inspection had not been sustained.

Broad Acres

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.

This inspection took place on 3 and 4 April 2017 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor and an expert-by-experience. Our advisor was a specialist in clinical governance and dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert at this inspection had experience of caring for a person who used this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

Before our inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eleven people who used the service and five relatives. We also spoke with a visiting advocate. We observed the care and support provided to people and the interaction between staff and people throughout our inspection. The provider is also the registered manager and clinical lead for this service and they were present throughout the two days of our inspection. We also spoke with the deputy manager, two registered nurses and care staff.

To help us assess how people's care and support needs were being met we reviewed eight people's care

records and other information, for example risk assessments and medicine administration records. We looked at four staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

People were not protected from avoidable harm and abuse. The generic staff training list did not include safeguarding training. The records we viewed during the inspection showed safeguarding training recorded as 'Pova booklet (hand-out) and Elder Abuse Questions and Answers.' In one staff record the Elder Abuse Questions and Answers section had not been recorded as being completed. After our inspection the provider sent us additional information that showed staff had received safeguarding training.

During our inspection we found an incident the circumstances of which had been the subject of an alert from the National Reporting and Learning Service (NRLS) in April 2009. This incident had not been recognised by the registered manager as of serious concern and it had not been reported to the local authority as a safeguarding concern or to any other regulatory body for investigation. No formal disciplinary action had been recorded in the member of staff's file. The file recorded that the member of staff was asked why the incident had happened but no reason was recorded. The staff file goes on to record that the person was given a verbal instruction that they were always to ensure that a male catheter was used for a male client, including right size. We confirmed with the registered manager that no other investigation had taken place into the incident to determine why it had happened and no actions had been put in place to ensure that a similar incident did not occur again. We also found that poor practice continued. This placed people at risk because the management of the service had not kept up to date with best practice and had not recognised the serious implications of this incident and had therefore not taken action to keep people safe.

Topical medicines were not managed effectively and the registered manager did not demonstrate an understanding of topical creams. We looked at the creams for four people. None had the date that they were opened. We observed the registered nurse applying a prescription cream to one person. The cream had R28-10-16 written on it. The nurse could not tell us what date the cream was opened. The deputy manager told us that the R was for the date the cream was received into the service. They told us that the cream had been received at the beginning of the month. The date topical creams were being opened was not being recorded to ensure that they were disposed of appropriately. Best practice was not being followed and therefore people were placed at potential risk.

Following discussion on the use of topical creams on the second day of the inspection they showed us a bag of various creams they had purchased from the chemist. There was no need to purchase such creams as they were available from the GP on prescription. The registered manager said, "You cannot get [proprietary brand] from the GP as he will not prescribe it." Other equivalent creams were in the British National Formulary that the service can order. The GP would then also be aware of all medicines being used and would be better able to appropriately prescribe.

One person had equipment for catheterisation stored in their wardrobe along with sachets used for bladder irrigation. The expiry date on the containers was 2016/05, making them past their expiry date. This was poor practice, the equipment and solutions should be checked and out of date products disposed of to avoid staff using them. A product which is out of date may be less effective and due to the time stored its sterility may not be guaranteed leading to a risk of infection.

We checked the number of medicines stored in the service against the recorded amount the service should have. We found that these were correct. However, we found that some medicines audits were not robust. This had led to the keeping of expired equipment in stock. The poor management or topical medication and the storage of expired equipment demonstrated that the management of medicines was not safe.

We reviewed the care plan for a person with a long term indwelling catheter. The Risk Assessment for catheter care and the care plan for Continence, did not give information on the size or type of catheter to be used. It did state that the catheter was to be, "Changed when necessary, long term catheter at least once every 12 weeks." There was no information concerning changing of the leg bags. Since September 2015 catheter changes had been recorded between 13 and as far apart as 15.5 weeks The catheter was not being changed as required in the care plan. On one occasion where it had been 15.5 weeks between changes the catheter had blocked and had had to be changed at 4am, this is not well planned, effective care.

We asked where the records of the type and size of catheter and type of bladder washout were recorded. Often this is on the MAR chart, so that types and sizes can be referred to.
The Deputy Manager showed us the folder where they recorded orders sent to the GP for equipment such as catheters, catheter bags and bladder washouts. This folder did not contain any details of sizes or types. We asked where they record when a bladder washout has been given, they said on the catheter change form. Bladder washouts should be signed for on the MAR chart as they are prescribed and frequency of administration should be recorded. This person had in their room boxes of both medium and long length urine drainage leg bags. We looked at their leg bag, it was attached to the top of their knee, making it difficult to access the drainage tap due to clothing. There is no guidance in the care plan as to which length of urine drainage bag was most suitable.

We asked the Deputy Manager about leg bag changes, they showed us the diary where it stated to change all leg bags on a Sunday. Weekly leg bag changes should be recorded in the individuals care plan and also details about daily night bag changes to ensure individual treatment plans.

We reviewed the care plan entries of one person. On 10 March 2017 it recorded, '[Person] had a very distended abdomen seen by GP catheter inserted ". There is a form, 'Monitoring of catheter change and Bladder washout'. This recorded, "10 March 2017, 6.30pm seen by GP, catheter passed 300mls size 12ch". There was no further information in the care plan concerning the catheter or its management. We asked the Deputy Manager if equipment had been ordered for this person from the GP, such as size 12ch catheters or urine drainage bags, they said, "No".
Information concerning the management of the catheter was not in the care plan for staff to follow. This placed this persons health at potential risk.

Not all equipment relating to the syringe driver was readily available for use. In the treatment room, there was a box with equipment for a syringe driver. This had been serviced on 5 January 2017. In the box there were three butterfly needles, there were no other cannula. The type recommended to be used are a needle introducer and a thin plastic cannula, which remains under the skin, this is less painful and causes less skin reaction. The butterfly needles are introduced under the skin and as the needle remains in place it can be uncomfortable for the person, especially when they move and is more likely to cause localised skin reactions.
We asked nurse if there were 30ml syringes, as these are required for this type of syringe driver. They were unable to find any, she later asked the Manager about this and came back to me to say that the Manager would order 30 ml syringes when they were needed. This was not acceptable as the service is supporting a person who has anticipatory drugs prescribed for a syringe driver and if the decision is made that they require these, it would be an expectation that it could be commenced immediately. Delay in providing the

anticipatory medicines could cause unnecessary discomfort and distress. We asked if this equipment was checked regularly, the nurse was unsure about this. When the Deputy Manager was asked they said that this box was not part of a regular check. All equipment should be regularly checked so that it can be used when it is required. All necessary equipment should be with the syringe driver and expiry dates should be checked.

These failings constituted a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12, Safe Care and Treatment.

The service was not following the UK Medicines and Healthcare Products Regulatory Agency (MHRA) advice on mouth care. We observed four people had a disposable mouth care tray; these were covered by the yellow plastic bag intended for disposal of the equipment. All the trays contained a number of foam swabs on a small stick and water in a part of the shaped tray.
Staff told us that the domestic staff changed the swabs daily. The MHRA sent out an alert on 12 April 2012 which stated, "The MHRA is aware of a recent incident in Wales where a foam head detached from the stick of an oral swab while a carer was providing mouth care to an elderly patient, the foam head could not be retrieved, the patient subsequently died".They advised to, "Check that the foam head is firmly attached to the stick before use. Do not leave the swabs soaking in liquid prior to use as this may affect the strength of the foam head attachment. If the patient is likely to bite down on the swab consider using an alternative such as a small headed toothbrush with soft bristles." The care plans for the four people we observed did not record the reason for mouth care, a risk assessment for providing mouth care in this way or any instructions for the carers to follow to ensure the procedure was carried out safely. All four of the people had a diagnosis of dementia. People were placed at potential risk because individualised assessments were not completed with specific care plans in place to guide staff. Staff were unaware and therefore there was a risk that they were not following best practice on the usage of disposable mouth care kits. Carers should have guidance to be aware of any potential problems.

One ground floor shower room smelt damp. Five disposal bins were stored in the room with a list on the wall of items to be placed into each. Two of the bins contained the same orange plastic bag for clinical waste. The bins were all by the side of the toilet and were accessible to people using the toilet and shower. The shower chair had a rubber non-slip mat on it. This was discoloured brown. We lifted the mat away from the chair and saw large amounts of brown staining and brown matter between the chair and mat. The grout between the tiles was discoloured. There were two dried flower arrangements attached to the wall. These were not suitable for a bathroom area as they hold dust and are not able to be cleaned. This poor cleaning practice placed people at risk of infection. Following us bringing this to the attention of the registered manager on the first day of our visit on the second day we saw that a new shower chair and non-slip mat had been put into the room and the maintenance man was cleaning the lower tiled area of the shower.

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

Despite this people told us they felt safe living at the service. One person said, "It is not a five star hotel, but that's not what [relative] is here for. [Person] cared for beyond what I can do at home. I simply can't manage [relative] anymore, here they do everything for [person]."

People who required a hoist to support them with transfers had a risk assessment in place for the use of the hoist. The size of sling to be used, which loops to use on the sling and the type of hoist were clearly documented in the care plan. The information was also in a folder in people rooms for staff to refer to. We

observed hoist slings in people's rooms and saw that these matched the ones that they had been assessed as needing. For example, one person had been assessed as requiring a particular type of sling. We saw that this was being used as it remained in place on their chair. This was good practice and ensured staff were using the correct equipment for safe transfers. However, we also found that some falls risk assessments were not consistent concerning people's capabilities. For example, the falls risk assessment for one person in the night and early morning fall risk assessment stated the person 'Will not call for assistance' but the Fall risk assessment (Part 1) stated 'Can use call bell appropriately'. This did not provide clear information for staff to enable them to meet this person's needs safely. Nor could this information be reliable to mitigate known risks.

People's views varied as to whether there were sufficient staff on duty to meet their needs safely. When asked about staffing one person said, "It's not bad here, though it depends on what staff are on." Another person said, "Weekends can be a bit dodgy." The service did not have a formal method of assessing the number of staff required to provide the care and support people required. We asked the registered manager how they arrived at their staffing levels. They referred us to their policy for staffing levels. They then went on to give us another document which they told us gave Royal College of Nursing staffing levels. This document gave suggested staffing levels for different size units but did not take into account dependency levels of people receiving care and support. Staff meeting minutes for 25 January 2017 recorded that 'Staffing levels were discussed and that all agreed that although there were enough staff on duty to ensure adequate care and supervision at all times they can at times need an extra hand for a while when 1:1 care is needed for some clients.' There was no explanation of how this was provided. People's care files did not contain an assessment of their dependency level. Without robust assessments the service cannot be assured that there were sufficient staff numbers on duty at all times to meet people's needs.

The registered manager did not follow clear disciplinary procedures when it identified staff responsible for unsafe practice. One member of staff had been identified as being responsible for issues relating to client safety and not performing their duties effectively. The registered manager had met with them and they had changed their role to office based because of the concerns identified. On the first day of our inspection we observed this person interacting with people organising a game of skittles. We asked the registered manager the reason for this and they told us that it was because they did not have an activities co-ordinator on that day. They confirmed that the person had not received any further training since their change in roles. Another member of staff had not followed moving and handling procedures resulting in a person falling to the floor. Records showed that further moving and handling training had not been addressed until three months after the incident. The person's staff file also recorded that the person was now not allowed to work unsupervised when carrying out any manual handling and transfers. This was confirmed by the registered manager. However, when we asked senior care staff if they were aware that this person was not allowed to work unsupervised when carrying out this activity they were not. In neither of these two incidents or the incident mentioned above, where the incorrect catheter was used, did the registered manager follow the service disciplinary procedure which forms part of the staff contract. We were not assured that the service followed clear procedures to ensure people received safe care and treatment.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation17.

Inadequate

Is the service effective?

Our findings

Our inspection of 2 February 2016 found a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the amount of fluid people were consuming was not being recorded effectively. At this inspection we found that the breach was continuing. For example we looked for the food and fluid chart for one person who staff confirmed stayed mainly in their room. Staff told us that the chart was kept in the lounge. At 12.35pm on the day of our inspection the only record of the person receiving any fluid was for 4.05am. Staff we spoke with told us that the forms would be completed between 1pm and 2pm that afternoon. The lack of contemporaneous records meant that staff could not ensure that they were accurately and clearly recording a person's intake. Therefore remedial action could not be quickly taken with regards to fluids. There was a risk that items could be missed or recorded inaccurately. This was vital to plan and deliver effective interventions.

Our inspection of 2 February 2016 found a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's individual needs were not met by the decoration of the service. At this inspection we found that the breach was continuing. The service had changed some aspects of the decoration but the overall design and decoration of the service did not meet peoples needs. For example some people had a wide black threshold in the doorway to their bedroom; there was the same between the two dining areas near the kitchen. The service supports people who live with dementia who were able to walk around the service. People living with dementia often have an altered perception of light and dark, this type of broad black area could be perceived as a hole and they may attempt to step right over it or not go into an area. This could cause them to become distressed if they feel unable to access their room or a dining area. If they attempted to step over the black area they could become unsteady and fall.

The corridors of the service were not well lit and many areas had glass lampshades that reflected shapes onto the ceiling, for a person living with dementia this could be perceived as objects being on the ceiling above their head. This may cause confusion about what the objects were and may also cause them to walk looking up at the ceiling and therefore more prone to falling. Some corridors had been designed with a section in the ceiling to let in natural light. Some of these had become discoloured and were not letting in a full amount of light. This further contributed to the poor light levels in the corridors. There have been many published guidance documents on dementia friendly environments. Social Care Institute for Excellence (SCIE) published guidance on the importance of light and appropriate décor in May 2015.

We noted that English was not the first language for a number of care staff. During our inspection we saw one occasion when a member of care staff did not have sufficient English to tell a person what their dessert choice was. We asked the registered manager and senior carer if care staff had sufficient written skills to complete the records required. They told us that when a person's written English was not of a good enough standard to complete reports these were completed by other care staff. The registered manager advised that whilst they encouraged staff with English as a second language to attend English language courses they were not pro-actively supported to do so.

The registered manager told us that they had not introduced training in the Care Certificate for new care

staff. The Care Certificate is the competencies that should be covered as part of induction training of new care workers. It should be completed by all care workers joining health and social care since April 2015. The registered manager told us that they had undertaken training as an assessor for the Certificate but had not introduced it for staff. The list of training provided to care staff did not cover all of the competencies in the Care Certificate. This did not demonstrate up-to-date plans to develop staff knowledge and skills.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that the service provided a choice of meal. However, this choice was not effectively communicated to people living in the service. One person said they, "Ate what [person] was given." A relative said that their relative, "Doesn't have a choice of dishes, but then [person] would get confused. What [person] gets seems very nice though." Another person said, "The food is good, but there is no choice." On the day of our inspection we were told that there was a choice of two dishes, a tuna pasta bake and steak pie. We only observed steak pie being served. An effective way to enable people living with dementia to choose is to show them plated options at the point of service. This was not observed to happen.

We observed the main meal in one of the communal lounges. People did not always receive the support they required to eat their food and enjoy their meal. For example, we observed one person was receiving support from a member of staff to eat their meal. We heard an alarm sound, the member of staff got up and left the person with no explanation or apology, a few minutes later they returned and continued to support the person with no verbal interaction. We also observed another member of staff approach a person who had their meal in front of them. The member of staff put some food on a fork and attempted to put it into the person's mouth saying, "This is good." The person replied, "No, please I cannot swallow." The carer then stood up and took the plate away with no further interaction.

People who chose to eat in their room were also not supported to eat and enjoy their meal. We observed one member of care staff leaning over a person in their bed as they were supporting them to eat and putting the food into their mouth at quite a fast pace. This person told us, "I like it here, they are all very kind and nice." We asked if the meal had been given to them too fast. They replied, "It is sometimes, I do ask them to slow down at times, I could swallow the ice cream easily today and I do prefer a small spoon." Another person who ate in their room and needed support when asked about their meal said, "I didn't like the pie crust or the swede, I only ate the potato and some ice cream, the other chef knows that I like extra veg, this one can't help it, [chef] doesn't know." They went on to say, "The nurse gave me lunch today and she was so slow, but that was better than usual as sometimes they go so fast I don't get time to chew."

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 authorisation 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. The registered manager kept a list of authorised DoLS and monitored when they required to be submitted for review.

Staff knowledge of MCA varied and not all the staff we spoke with knew which people were subject of a DoLS nor had a good understanding of the MCA. One member of care staff, after some thought said, "It is about choices," but another said, "I cannot remember." This knowledge is part of the Care Certificate currently not offered at this service to staff.

In our report of 2 February 2016 we noted that people did not get choice as to how they lived their daily lives. This lack of implementation of the MCA continued at this inspection. We found that people's wishes were still not being followed as to whether their doors were open and what time they went to bed because night staff liked to keep bed room doors open. One person said, "I have someone to help me up at about 7.30am and then to help me to bed around 9.30pm to 10pm. They leave the door open to keep an eye on us." They went on to tell us that this meant they usually turned off their television at this time so as not to disturb others. Another person said, "I begrudge turning off the television, It's not very loud is it? Don't see that it would disturb anyone." They went on to tell us they had to turn it off between 10pm and 11pm. A third person told us, "Everything has to be turned off at 9pm." When we asked what happened if they wanted to watch a programme after 9pm they replied simply, "You can't." Two people told us that they had complained but that they had been told that the noise would keep other people awake.

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

People were supported to access healthcare services. Care plans recorded when people had accessed support such as the optician and dentist.

Requires Improvement

Is the service caring?

Our findings

During the two days of our inspection we observed widespread examples in the caring attitude of staff. These ranged from very positive to very poor. An example of a very good interaction was when we observed a person being administered eye drops and having cream applied. The member of staff clearly explained what they going to do. While they were carrying out the task they asked about the person's day and reassured them about the treatment they were carrying out. This meant the person was relaxed and happy as they received their treatment. A poor example of an interaction occurred during the lunch time meal where a person asked a member of staff, "Will it be alright if I go to the toilet?" and pushed the small table away from in front of them. The member of staff simply grunted and pushed the table back in front of them and walked away. They did not make any attempt to speak with the person. This resulted in the person repeatedly calling out to staff. We also saw that drinks and snack whilst being offered regularly were not always left within easy reach. This may demonstrate that the kindness and compassion observed was due to the skills and efforts of individual members of staff rather than an expected standard of care that was ensured through routine monitoring of staff practice.

We also observed a person in their bed room at 11.30am. They had a soiled napkin and tissues under their chin. Their beard was untidy and quite long in length, it contained food particles. They were sitting in their chair, their bed table was cluttered, and there was an empty water jug and a dirty glass on the table which was sticky. They said, "I stay in my room, I don't go to the lounge, they've got different taste to me, I like music." This person's room had an unpleasant odour with an open bag of medical devices on a footstool in front of the television. There was a large, round wet patch on the carpet in the middle of the room. When asked, the person said they did not know what the wet patch was. We observed a cleaner shampooing and cleaning this area later that afternoon. We observed another person eating their dessert in their room at 12.30pm. This person had a protective sheet on their lap. They had dirty fingernails and looked unkempt. All of the men observed on the day of our inspection were wearing jogging type trousers with elasticated waists. This was not recorded as the person's choice in any of the male care plans. This did not demonstrate the provision of compassionate, caring and respectful care and support.

Another person told us about the fan that was in their room. They said, "I like the window open but they say it's draughty for others and that worries me." This person's room did not have another room opposite where a draught could have been a problem. When we left they asked us to leave the fan off. Later that day we observed that the fan was switched on. This did not demonstrate that the service was taking the person's wishes into account to have their window open for fresh air.

There was a noticeboard in one of the service lounges. This clearly displayed information about a person's nutritional needs. There was also information displayed on noticeboard for staff about food thickening and the management of falls. Displaying this type of information does not demonstrate respect for people's privacy and dignity.

Inadequate

Is the service responsive?

Our findings

People did not receive care and support which was responsive to their needs.

We observed one person who had pressure relieving equipment on their legs and heels. However, the equipment for their heels had not been secured and was not covering their heel. We noted one area which looked very fragile and if the skin were to break down it could develop into a pressure ulcer. We asked if this had been recorded and care staff told us that the nurse would record this in the care plan. We looked at the care plan but there was no record that this area had been seen or documented. There was no record in the care plan of the use of pressure relieving equipment. There was a chart entitled Ulcer and Pressure sore/wound Assessment Record and Care Plan in this person's care plan. Entries in this recorded two pressure ulcers but there were no photographs or measurements and no indication of how often the wound should be redressed. All pressure ulcers should be measured and photographed to assess if improving or deteriorating to enable and determine the treatment options. Various different products had been used but no rationale was given as to why changes had been made. This meant that the service was not able to assess if the treatment being provided was effective in improving the pressure ulcers.

We asked the registered manager how staff knew when wound care should be carried out. They said that following advice from the County Council they had put a form entitled Dressing Plan for all Clients in the handover folder two weeks ago and had instructed staff to look at this every day to see who required a wound dressing. This form states that the person referred to above should have their wound dressed on a Friday, Sunday and Tuesday. From 27 February 2017 to 2 April records indicated that the person had had their wound dressed on Monday 27 February, Thursday 2 March, Monday 6 March, Friday 10 March, Friday 17 March, Tuesday 21 March, Saturday 25 March, Monday 27 March, Friday 31 March and Sunday 2 April. This does not follow the dressing plan. This meant that the service was not providing the care and support for the person's pressure ulcers that they had been assessed as needing. This person's health was put at an on-going risk.

Another person with a recurrent ulcer in the care plan had photographs taken. These were dated but had no name on them. The person holding the ruler near the wound was not wearing a glove. The wound assessment and care plan gave two areas requiring dressings. One area was recorded on 17 November 2016 as measuring three centimetres by three centimetres. There were no further measurements recorded until 15 February 2017 which stated large two and half centimetres. The next measurement was recorded on 20 March 2017 with an area of eight centimetres. There was no comment on the increase in size. On10 March 2017 this same person was recorded as having a one and half centimetre pressure ulcer on the left knee. Action taken was recorded for that day but this area was not mentioned again in the wound care records. Records show that the person was seen by the wound care nurse on 21 February 2017 who prescribed a particular dressing to be left on for one week and then renewed. The dressing plan for this person showed that the guidance given by the wound care nurse was not followed. It is difficult to ascertain from the records when this person's wound required redressing and what dressings were being used. There were no regular wound measurements being taken and reasons for the change of types of dressings were not explained. There were photographs of the wounds but these were not referenced from the care plan. This

did not give effective records of how a wound was improving or deteriorating, so that appropriate and timely management can be planned around this. This person's health was put at on-going risk.

There were not effective preventative methods in place to stop people from getting sore skin. One person had a form in their room entitled 'Turning'. From 1 April 2017 and 2 April 2017 the form recorded the person had been turned on three occasions each day. For 3 April at 6.15am it recorded up in chair, a further entry at 2.20pm recorded upright pad changed. The person was sitting upright in their chair. We asked a member of care staff when the person went to bed. They said, "She goes later." We asked if the person had a pad change before going to bed. The member of care staff replied, "Not usually unless we think she has had her bowels open." This was poor practice. The person was being regularly transferred out of bed at 6am and then their position was not being changed or incontinence pad being changed for approximately eight hours. People who were immobile should be re-positioned four hourly as a minimum. This would ensure that pressure areas are checked and circulation to the body is improved. If a person lies in the same position on their side the lungs are not able to inflate properly and it increased the risk of chest infections. Incontinence pads are designed to contain a certain amount of urine, they will not normally be absorbent enough to hold urine passed over an eight hour period without leakage occurring. People were placed at potential risk due to staff practices. If the person has their bowels open and the pad is not checked for eight hours excoriation of the skin will occur when faecal matter is left on the skin. This will cause discomfort and irritation to the skin and skin may breakdown causing pressure ulcers.

Pressure relieving equipment in place was not set to ensure it performed effectively and provided the required pressure relief to meet people's needs. One person had a pressure relieving mattress on their bed set at 70kg weight and an electric pressure cushion. The person's weight had been recorded on 19 and 25 March 2017 as 49.8kg and on 1 April 2017 as 50.1kg. When air mattress's or cushions are set above a person's weight they still give pressure relief to the body but it is not so effective. The cells inflate to a volume hard enough to support a heavier weight, a lighter person may find this uncomfortable to lie or sit on. The alternating cells also do not deflate as much if a high setting is set as it is expecting a heavy weight so less pressure relief is obtained by a lighter body. The care plan for this person stated 'Pump is set according to client's weight. This [person] is on weekly weights so pump to set accordingly and checked each week by staff.' There was no record in the care plan of what the setting should be for the cushion or mattress. This practice placed the person at risk of developing sore skin, because the air wave motors were not set at the correct weight for the person to give maximum pressure relief. The setting was not recorded in the care plan for carers to check against to ensure the motor setting corresponds to the person's weight.

We observed that one person was sitting on a pressure relieving cushion in a chair in their room. The cushion had a split plastic cover, sections of the plastic had gone hard, normally the cover of the cushion is soft and pliable. They were sitting with just an incontinence pad on, their clothing was around her waist. We asked them why their clothing was placed like this and they said "I don't want it to get wet". We spoke with the Manager about the cushion and the need for a new one and to put a cotton layer between the cushion and the person's bare legs to prevent them becoming sore and to make them more comfortable. The service had not fully assessed this person's pressure care needs and explored the best options to meet them and were using equipment which had become brittle and split The equipment was in need of replacement/repair and this persons dignity was compromised.

Care plans did not always reflect the care and support being provided for people. We observed that one person had a repose overlay on their bed; this was a static, pump up pressure relieving overlay. The care plan for this person had a form, "Risk assessment for electrical appliance/equipment used. " This was dated 23/10/14. It states that, "[Person] is nursed on an electrical air mattress whilst in bed. Also, An air cushion is used whilst sitting out of bed ".

This has been signed monthly, the last signature being recorded on 8 March 2017 and all recorded, "No change. " We observed that this person was sitting on a repose cushion. The care plan stated that they had an electric air cushion. The review sheet on the reverse commenced on 29 December 2014 had all reviews recorded as, "No change," the most recent date of 20 March 2017 also recorded "No change." This was not an accurate record of care and treatment in place. There was no record of when an electric pressure relieving mattress and cushion were changed to the static type. This information should be recorded accurately as it related to the management of pressure ulcers and any deterioration of the skin may be attributed to the change of equipment. The staff signing the review had not checked the type of equipment being used.

People's care plans did not contain details of their likes and dislikes or their personal preferences. For people living with dementia this would enable staff to provide care and support which met their preferences. The service was also supporting a person with mental health needs. We spoke with the advocate for this person who told us that the person had made progress since moving into the service. However, the person's care plan contained only brief information regarding their interests or who their family members were for care staff to read and refer to. This was vital for a person living with the diagnosis that this person had so that care staff knew who they could speak about and what their connection was to the person and how involved they were currently in the person's social circle. It is also important to have interests, hobbies and the person's capabilities assessed and recorded. There was no record of future plans for this person or a referral to occupational therapy to maintain normal daily activities with a view to future accommodation that was suited to their needs.

During our two day visit the only activities observed were a game of skittles organised by the member of staff who the manager had acknowledged did not have the required skills. One activities person was on holiday and the other had called in sick. Staff did not take over any of this role. We observed staff sitting in a small area outside the lounge, with a person that required one to one supervision; they used this time to complete records. We also observed a member of care staff sitting in the lounge with people that required regular observation. They did not talk or engage with the people. This member of care staff's first language was not English and they were not fluent in English, this has inhibited their ability to communicate with people.

We looked at the "Activity Folder ", this was completed by the activities staff. This was a large folder with many pages for each person; the manager had hand written all the care plans concerning activities, the dates of these were not current. One person had care plans dated 4 October 2010 and also 15 January 2013. Not everybody living at the service had an activities care plan.

One person's record had written in large letters over the page, "Refused to take part in any activities or one to one activities. Spend the day in her room ". The activity staff had recorded on several occasions that they have gone to this person's room and sat and spoken with them.
We spoke with this person who said, "I chose this room, I like to be quiet, I have that gate on my door to stop people wandering in." We asked about activities, they said, "I like to read, I have a newspaper every day and I read all of it, they don't tell me about activities, I don't like music, so I probably wouldn't go." We asked if staff came down to the person's room to be with them, "They haven't got time, they're always rushing about." We asked when they rang their call bell how quickly staff responded. The person said, "They always come, not quickly as it's a long way to come down here, sometimes I only see people when they bring food." This person was not having their social needs met and had become socially isolated.

All of the above demonstrate numerous breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not use concerns as an opportunity for learning and improvement. For example the service had not taken any action when people had raised concerns about lack of choice in their daily lives. Also poor staff performance relating to medical procedures and moving and handling were not investigated thoroughly and used as an opportunity to improve practice.

Relatives told us that they could visit the service at any time and felt welcomed. They told us that they were kept informed of any issues that arose. An example of this was when the service recently had an incident where the fire brigade attended and the service had telephoned relatives to reassure them as to the safety of their relative.

Inadequate

Is the service well-led?

Our findings

Our inspection of 2 February 2016 found a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered manager could not demonstrate how they kept up to date with best practice and explored opportunities for improvement. At this inspection we found that the breach was continuing. At this inspection we also found that quality assurance systems and clinical governance systems were not effective and were not used to drive improvement.

The management of the service was not keeping up to date with safety alerts such as the use of catheterisation equipment and equipment for providing mouth care. This had resulted in unsafe practice.

On discussion with the registered manager concerning the training and observed practice for registered nurses to perform certain procedures they were unaware of the need for signed records of observation. They told us that they were carrying out competency checks and observations for procedures such as catheterisation but were unsure of what level of qualification or competency they should achieve to do this. The registered manager did not understand their responsibilities.

With regard to the incident where incorrect equipment had been used the serious consequences of the incident had not been recognised. This meant that the disciplinary procedure for the registered nursed had not been followed and that appropriate safeguarding referrals had not been made. As the management of the service did not recognise and report such incidents we cannot be confident that other incidents have been reported and investigated appropriately.

The provider and registered manager of the service was also the clinical lead and a registered nurse. They were the only registered nurse who was reviewing nursing care plans. The Deputy Manager was not a registered nurse, they had completed medication training so were able to administer medicines. On the first day of our inspection the registered manager was the only registered nurse on duty in the morning with another registered nurse coming on at lunch time. On the second day an bank registered nurse was working, this was their third shift at the service. When we asked the bank nurse if they had had a handover they said that they had. We asked if she had been given a list of people's names and room numbers. They said, "No but I have written down who is diabetic and who needs tablets at set times like 10 o'clock Parkinson's tablets, someone helped me with the medicines as I do not know the people." As the bank nurse had been given limited information and the care plans did not provide clear guidance to staff on meeting people's needs there was a risk that they did not have the information they required to perform effectively.

Our previous inspection had also identified that the quality assurance systems in place were not robust and did not identify shortfalls in the quality of the service provided. The registered manager provided us with an action plan detailing how they would address the issue. This action plan had not been effective. For example the action plan addressed the issue of keeping accurate and timely records of people's fluid intake and that actions would be completed by 12 May 2016. This action had not been sustained. The audits had not identified shortfalls in the cleaning of the service. The service had also failed to act on known risks. Risks known by the manager were not proactively addressed.

Following our previous inspection we met with the registered manager. During the meeting they had advised that they would be looking into how they could improve the service to support people living with dementia by visiting other services and developing links with local dementia support services. At this inspection they told us they had visited two other services that supported people living with dementia to gather good practice. Some minor changes had been made to the decoration of the service to support people with dementia. However, as demonstrated in this report this had not been carried through to the whole of the service. The registered manager told us that they had not developed any links with support services for people living with dementia. This did not demonstrate a commitment to improve and provide a good quality service for people living with dementia.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9(1)(a) Care provided was not always appropriate for the person. 9(1)(b) Catheter management was not adequately managed or recorded. People did not get the support they required to eat their meals. Pressure reliving equipment was not used appropriately Wound and pressure care was poor, not adequately managed or recorded. 9(1)(c) There was poor choice of food. People did not always get choice as to how they lived their daily life. Care plans did not contain sufficient information about people preferences, interests and family history

The enforcement action we took:

Imposition of conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) A serious medical incident had occurred, it had not been recognised and such and no investigation or action to prevent further occurrence had been taken. People were receiving mouth care unsafely, contrary to an alert by the MHRA. (2)(g) Topical medicines were not managed effectively. Medical equipment was not checked and stored correctly.

The enforcement action we took:

Imposition of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment 15(1)(c) The decoration of the service did not support people living with dementia. The premises were not managed to keep people living with dementia safe. 15(2) Cleaning and maintenance was not effective.

The enforcement action we took:

Imposition of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) Disciplinary procedures were not followed by the manager. There were no established systems to keep up to date with safety alerts 17(2)(a) Quality assurance systems were not effective. 17(2)(c) Contemporaneous records of fluids were not kept

The enforcement action we took:

Imposition of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18(2)(a) Staff were not effectively trained and their competency checked.

The enforcement action we took:

Imposition of conditions