Long Meadow (Ripon) Limited

Long Meadow Care Home

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

Following receipt of serious concerns from external health and social care professionals we inspected Long Meadow Care Home on 8 and 13 April 2016. This was an unannounced inspection which meant that staff and the registered provider did not know that we would be visiting. We visited to check the actions the registered provider had taken to safeguard people who lived at the home.

We had carried out a comprehensive inspection of Long Meadow Care Home on 8 April 2015 where breaches in two of the legal requirements were found. The registered provider had failed to take proper steps to ensure care was planned and delivered in such a way that it ensured the health and safety of people. They had also failed to ensure there were sufficient, skilled and qualified staff employed at the home.

We asked the registered provider to send us an action plan outlining what steps they would take to ensure the home complied with the regulations. The registered provider failed to send this action plan. We are dealing with this matter outside of this inspection process.

Long Meadow Care Home is registered to provide residential and nursing care for up to 47 older people some of whom are living with a dementia. At the time of this inspection 29 people were living at the service and we were told that one of these individuals was in hospital.

The service does not have a registered manager. 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. A registered manager had been in post from 20 October 2015 until 9 February 2016.
The area manager who was also the nominated individual was working at the home and taking day to day charge.

At this inspection we found that there were breaches of 10 of the Fundamental Standards of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, person-centred care, nutrition, dignity and respect, consent, safeguarding, staffing, recruitment, dealing with complaints and the overall oversight of the home. Also, there were failures to meet the requirements of regulation 18 of the Care Quality Commission (Registration) Regulation 2009 requirement to notify.

We had very serious concerns about the service provided at the home and found that staff had failed to meet the needs of the 29 people who used the service.

The registered provider had failed to ensure all of the people who used the service had received safe and effective care and treatment. We found they had not taken reasonable and practicable steps to mitigate the risks posed to people who used the service.

Care was delivered in ways that placed people who used the service at risk of exposure to significant risks to their health, safety and welfare. Some people had experienced acute illnesses which should have resulted in emergency services being called but the nurses on duty did not recognise these problems. In addition to this nurses were not meeting people's needs. For example, people with unstable diabetes had not always received the appropriate treatment. Medication errors had led to people not receiving their required medication. We found that people had experienced avoidable harm such as dehydration, infections, missed percutaneous endoscopic gastrostomy (PEG) feeds, urinary catheter blockages where action was not being taken to mitigate risks.

The oversight and management of medication was inadequate and there were errors in the administration of medicines and the way these were recorded. Although the registered provider was aware of concerns relating to medicines they took no action such as daily checks, weekly audits to identify the source and eradicate the problem.

We found that GP and community nurse's guidance was not adhered to, for example the GP requested that one person had blood taken for a test and over the course of the next six days this was not done. Emergency services, GPs and community nurses were not always accessed in a timely manner, which led to people not receiving the care they needed. For example one person sustained a head injury and the GP asked staff to completed half hourly observations. The records and discussions with staff showed that this had not happened. We found that the staff were not identifying and reporting safeguarding concerns.

The lack of registered manager, clinical oversight and leadership within the home had contributed to people who used the service being placed at risk of harm. This was because there was no continuity of care or effective sharing of essential information about changes to individual's needs. Nurses, who had been identified as not fit to practice continued to be deployed at the home.

There was a lack of suitably skilled and experienced nursing staff employed and the provider relied on agency nurses to provide nursing care and support to people on a day to day basis. They had failed to check that agency staff had the skills and competencies needed to deliver the care and treatment that people needed such PEG feeds, and stoma care. Insufficient numbers of staff had received training in first aid.

There was a lack of information and guidance to ensure the care needs of people were met. In four of the 14 care records we reviewed we found that people had not been assessed and care plans were not in place. Other people's care plans and assessments were inaccurate or out of date.
We found that the windows needed restrictors in place that could not be detached.

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 enforcement action, 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 and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

We found that people who used the service had not been safe. Medication was not handled, stored or administered appropriately.

Staff had not met people's needs or ensured risks to people from the environment were reduced or minimised.

There was insufficient suitably qualified and experienced staff employed to meet people's needs. There was an over-reliance on agency staff and appropriate checks had not been completed before they worked at the service.

Is the service effective?

Inadequate

We found that service was ineffective.

Staff did not have the skills needed to provide care to meet the needs of the people who used the service.

The registered provider failed to ensure first aid training was in place for the permanent staff members or that agency staff were competent to provide the care and treatment people needed.

The requirements of the Mental Capacity Act 2005 were not met. Some people spent most or all of their time in bed. Staff put this practice in place without considering people's rights or the impact this isolation would have upon their wellbeing.

Staff did not ensure people received adequate amounts of foods and fluids.

People's healthcare needs were compromised as staff did not follow GP and, community nurse advice or ensure they were seen by health professionals in a timely manner.

Is the service caring?

Requires Improvement

We found that the service was not always caring.

Staff were kind but lacked the skills and knowledge needed to ensure they developed therapeutic relationships.

There was an over-reliance on agency staff for all aspects of the service and this led to inconsistencies in care.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always assessed or care plans produced. Care plans were not accurate or reviewed on a regular basis.

People did not receive personalised care that was responsive to their needs.

People were not engaged in any meaningful activities.

When people raised concerns, staff did not recognise them as complaints or identify allegations of abuse so did not pass these to the appropriate authorities.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had not ensured that systems were in place to ensure people who used the service were safe, received effective, caring and responsive services which met their needs.

The registered provider had taken no action to mitigate the identified risk to people.

There was no clinical leadership and limited managerial oversight of the home.

Long Meadow Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 8 and 13 April 2016 and was unannounced. The inspection team consisted of two adult social inspectors and on the second day one of the adult social care inspectors commenced the inspection at 6am.

The registered 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.

Before our inspection, we reviewed the information we held about the home and information from meetings held with the local authority commissioners and the Clinical Commissioning Group (CCG).

Over the course of two days we observed the care provided to people who used the service. We spoke with 14 people who used the service, one relative, the registered provider, the nominated individual, three agency nurses, six care staff and a domestic.

We also reviewed 14 sets of care records, one staff record, 12 agency staff members' files and the medication records, as well as records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection of the service, in April 2015 we found there were no permanent nurses employed and all of the shifts were covered by agency nurses. No deputy or clinical lead was employed at Long Meadow Care Home, but a nurse had been appointed as the manager.

At this inspection we highlight that the lack of permanent staff was adversely impacting the care and treatment being provided to the people who used the service.
In April 2016 we received information of concern from the local authority and Clinical Commissioning Group (CCG) about a lack of nurses recruited at the service. They highlighted that the registered provider continued to heavily rely on the use of agency nurses to take day to day charge of the service. Concerns were also raised about the general competency of the agency nurses working at the service. Also, that since July 2015 there had been increasing numbers of medicine errors. The Coroner had raised concerns about the treatment people had received at the home.

At this inspection we found that there was no improvement in relation to our previous concerns regarding the lack of nurses employed by the service. From discussions with the area manager, the staff on duty and a review of the staff rotas we found there were only two permanent members of nursing staff. The area manager confirmed that these two nurses provided a total of six hours cover each. The remaining shifts were covered by agency nurses. We found that 11 care staff were employed and that all other cover came from agency staff. We saw that this led to occasions when all of the staff on duty, particularly overnight, were from an agency and at times all were completing their first shift in the home.

Although the area manager told us they tried to use the same agency nurses we found that since November 2015 over 30 different agency nurses had been used to ensure total coverage of all shifts. This meant the registered provider had no assurance that the care and treatment being delivered was consistent or that the different staff were fully aware of each person's needs.

The area manager was not a nurse and there was no clinical lead or deputy employed at the home. We found there was a lack of continuity in clinical oversight and decision making in respect of people who used the service. This absence of a permanent staff and clinical oversight meant that people's health and welfare had been compromised.

Information held centrally about each person was minimal and we observed that the handovers provided limited insight into the overall needs of each person. We could not be confident that staff were made aware of the pertinent information they needed to keep people safe. We found from the records that vital nursing actions such as taking bloods, administering medication, monitoring head wounds and PEG feeds (a means of providing nutrition when people cannot swallow foods) had been missed.

On 11 April 2016 the local CCG pharmacist had visited the service and reviewed medication practices from January to April 2016. They found multiple errors in relation to the administration of medicines such as missed doses, crossing out of signatures and miscalculations of stock. When we visited on 13 April 2016 we

found no action had been taken to report these failings to the appropriate authorities such as the safeguarding team. .

From our review of the medication practices on 13 April 2016 we found the nurses had not followed the prescription directions for strong pain relief including opiate based drugs. For example, one person was prescribed a pain relieving patch, which was to be administered every 72 hours. The life expectancy for each of the patches is 72 hours. This means that after 72 hours the patch no longer issues pain relief and the person can expect to experience pain. We found that patches for this person had not been changed after 72 hours.

On 7 April 2016 concerns had been raised by visiting professionals about the medicine practices of an agency nurse. The agency nurse had been responsible for the errors noted in the CCG pharmacist audit. We also found that this agency nurse had missed a PEG feed for one person. Despite the area manager having been made aware of these discrepancies we found they continued to allow this nurse to work unsupervised. This action could have led to more errors occurring and thorough investigation of the errors not being completed.

We found that no action had been taken to mitigate the risks posed to people's health and safety from the failures to appropriately administer medicines.

Bedroom and bathroom windows on the first floor had restrictors that could be detached which meant people who used the service could be at risk of falling from the building. When we discussed these concerns with the maintenance person they stated that these restrictors had been in place for 'some five years'. The maintenance person told us they were unaware of any of the Health and Safety Executive guidelines. They agreed to replace the window restrictors when we alerted them to the dangers.

This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the previous registered manager and area manager failed to recognise when incidents or allegations would be considered to be abuse and therefore need referring to the local safeguarding team. Although permanent staff had received safeguarding training they did not know they could raise safeguarding alerts.

Since the beginning of 2016 numerous safeguarding alerts have been raised in respect of staff practices. However, these have often been identified by visiting healthcare professionals and other interested parties not the staff who work at the service. On 6 and 7 April 2016 representatives from the local authority visited and identified and alerted in excess of 10 safeguarding concerns that had not been referred to the local authority by staff at the service. When we visited on 8 April 2016 we found additional safeguarding incidents such as failure of agency nurses to administer PEG feeds, failure to provide sufficient fluids via the PEG, failure to safely manage a person's diabetes and staff failing to adhere to other healthcare professionals' instructions. We asked the area manager to report these matters to the local safeguarding team. However, when we visited again on 13 April 2016 they told us they had not done this. This meant people were not being safeguarded.

This was a breach of Regulation 13 (Safeguarding people who used the service from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Over the last 12 months the registered provider has submitted three statutory notifications in respect of

allegations of abuse. However, we found that in excess of 30 safeguarding alerts have been made and the Coroner's office has commenced two investigations. All of these incidents should have been reported to us and were not.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found the area manager had limited time to provide any oversight of the home as her time was taken trying to cover shifts, manning the phone, dealing with finances and the administration tasks expected in a care home. We observed they could not undertake and complete tasks as they were frequently interrupted by telephone calls and requests from the staff for advice and support.

No administrator was employed and only one senior care worker was available for work as the other was on extended leave. The senior care worker's remit was to organise the care staff and not to support the nurses in completing their tasks. Therefore no one was in charge of ensuring identified actions such as taking bloods, monitoring medication management arrangements and producing accurate care records was completed.

We saw that it took the agency nurse in excess of two hours to administer the morning medicines to the 29 people at the service and this left very little time for them to attend to wound care, PEG feeds, liaison with GPs and community nursing teams. We noted that 11 people were bedbound and required two-hourly positional changes and over a third of the people required two staff to attend to their care. Overnight one agency nurse and two care staff were on duty and we saw that they could not meet everyone's needs in a timely fashion. For example the care staff were busy attending to one person's needs whilst another three people had activated their nurse call alarms to request assistance. Every two hours a minimum of 11 people needed assistance to change their position, which took two staff; people also needed assistance with personal care, management of urinary catheters, the delivery of PEG feeds and administration of their medication. We also identified that in addition the night care staff were required to complete domestic and laundry tasks.

Through our observations and discussions with staff members we found there were not enough staff throughout the 24 hour period to meet the needs of the people who used the service. There was insufficient clinical oversight to ensure consistency in the delivery of nursing care. We discussed this with the registered provider who agreed to increase the number of care staff on night duty, to increase the number of nurses on duty who would receive dedicated support from the care staff and to provide an administrator.

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

The area manager told us that a new manager had been appointed. We asked to see their recruitment records to ensure that a robust recruitment procedure had been followed. Records were not available to confirm that the validity of their application, their professional references or registration with the Nursing and Midwifery Council (NMC).

The registered provider used agency staff and these agencies had provided staff profiles but not the packs of documents to verify the details such as certificates of training, work visas and NMC registration information. We found the registered provider had not taken any action to verify that all the information on these forms were correct. Therefore they could not be assured that the agency nurses they were using were fit to work at the home. We found that the registered provider's recruitment processes and checks were unsafe.

This was a breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found there was an extremely malodourous smell in many areas of the home. Some toilets were dirty and bathrooms had not been cleaned. On the second day of the inspection we discussed this with the registered provider who said they would address this immediately.

Inadequate

Is the service effective?

Our findings

The area manager could not provide evidence of checks of the agency staff to ensure they had the necessary competencies to provide care and treatment to people who used the service. We found the registered provider had given no consideration to their responsibilities to ensure staff were suitable to work at the home.

On some occasions the agency nurses working at the home were registered mental health nurses but no checks had been completed to ensure they had the skills and competencies to care for people who had conditions such as unstable diabetes, who required PEG feeds, or stomas or urinary catheters. We found some of the nursing staff lacked the skills and competencies to ensure people safely received the care they needed. For example one nurse had not correctly commenced a PEG feed, which was subsequently discovered by the nurse who corrected the error and ensured the person had their feed.

On 13 April 2016 the agency nurse on duty was different to the one listed and when we checked this discrepancy we established that the area manager had been unaware of this change. They had no information about this nurse's qualifications or details to verify their identity. In discussion with us this agency nurse confirmed they were unfamiliar with people's needs and had to rely on care staff to tell them what people needed. This meant unknown staff were working with people and staff were taking charge of the home without an understanding of individuals' needs.

No action was taken to ensure the agency staff had received the training they required.

Due to the lack of managerial staff at the home staff supervisions in general had not been occurring since the beginning of 2016 and staff had not received annual appraisals.

Although safeguarding allegations had been substantiated in relation to the nurses not have first aid skill the registered provided had not taken action train enough staff in first aid at work to cover every shift. Only four care staff held first aid at work qualifications and none of these staff worked at night. Also the rota showed that frequently these staff worked together and this led to first aid cover not being provided every day. Also the registered provider had not ensured agency nurses had been train in first aid.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations.

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 care records we reviewed contained limited assessments of the person's capacity to make decisions.

We found that the staff had a limited understanding of the MCA and what actions they would need to take to ensure the home adhered to the code of practice. We found there were no capacity assessments even though evidence suggested some people might lack capacity. Care records did not describe the efforts that had been made to establish that the least restrictive option for people was followed and the ways in which staff had sought to communicate choices to people. There were no records to confirm that 'best interest' discussions had taken place with the person's family, external health and social work professionals or senior members of staff.

Staff had failed to ascertain the legal status of family members when making decisions for people who used the service. No information was available to determine if relatives had lasting power of care and welfare or had been appointed as a deputy by the Court of Protection. Staff we spoke with were unaware of the restrictions on a person's ability to make decisions for others and the need to have the legal authority to make care and welfare decisions.

This was a breach of Regulation 11 (Need for consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection the registered provider information return stated that 15 of the people using the service had been subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. However, throughout the inspection we could not find any information about who these people were or whether the authorisations were current. We asked for, but were not supplied with, records showing when the DoLS had expired and it was difficult to find the actual DoLS documentation as this was not stored in the care records. The staff could not tell us who was subject to a DoLS authorisation and it was clear from the lack of capacity assessments in relation to newly admitted people that consideration had not been given to whether they were being deprived of their liberty. We were unable to verify how many people were subject to a DoLS authorisation.

This was a breach of Regulation 13(5) (Safeguarding people from abuse and improper treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received no statutory notifications in relation to people being subject to a DoLS order therefore we could not be clear whether the information in the provider information return was correct. Legally we should have received a notification each time a determination was made about a DoLS application so should have received at least 15 notifications.

This was a breach of Regulation 18 (Notifications of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

We found from one person's daily food and fluid diary that the diabetic nurse's guidance regarding offering fluids on an hourly basis had not been followed. The records showed that they were only offered five drinks each day and on occasions they had refused the drink. The lack of action to offer more regular drinks went against the advice of the diabetic nurse and NICE and recognised best practice guidance for the management of high blood sugar levels, which states that a trigger for an increase in blood sugar levels in people with diabetes is dehydration.

The daily notes also recorded that one person was refusing to eat. The staff had started to record their daily food intake but had not developed any care plans around this issue. There no evidence to show the district nurses, who were administering this person's insulin, had been made aware of this concern. If they had been they could have checked if it was safe to administer that dose of insulin.

On our first visit to the service we found people who had not received their PEG feed either in line with their prescription or at all and who had not consistently received sufficient fluid. We discussed these matters with the area manager at our first visit but found when we returned no action had been taken to rectify them. The nurses we spoke with were unaware of these issues which meant they were prevented from taking steps to prevent these errors being repeated.

This was a breach of Regulations 12 (Safe care and treatment) and 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

We found 11 people remained in bed throughout the day but their care records did not reflect any information about whether they had consented to this and the consideration staff had given to ensuring this action was not depriving these people of their liberty. We spoke to several of the people confined to their bedrooms and found they had become accustomed to being left in bed but felt very lonely. One person told us, "I feel quite deserted, as I ask staff to come but they rarely do and can spend so little time here." Staff could not explain why people had to remain in bed.

We observed that one person spent the two days in their room with minimal contact from staff and with no entertainment. Staff only entered the room at meal times and when personal care tasks needed to be completed. We found that no consideration had been given to the impact on these people or if this was the least restrictive option.

This was a breach of Regulation 13(5) (Safeguarding people from abuse and improper treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, "They are good and kind." And "I find that they always come when I need them. I find they make sure I have plenty to eat and drink and they all seem very kind." And "It is so so here, if I could move I would." And "It gets a bit lonely stuck in bed all day but suppose the staff can't do any more than they are."

Some people who used the service were living with a dementia and were unable to tell us about their experiences in the home. We spent time observing the interactions between the staff and people. We observed staff treating people with kindness and staff spoke with people at a pace which appeared comfortable to them; staff knelt down enabling them to make eye contact.

We observed every time a staff member went past one person's room they called in, spoke and reassured them. However, they did not appear to have sufficient time to sit for any length of time with them which may have helped to reduce the person's agitation. We did see some people who sat for long periods during the morning and afternoon with only occasional contact when staff spoke to them in passing. During this time we noted staff were busy with other tasks.

We found that 11 people who were cared for in their rooms experienced extended periods of time in silence as staff did not assist them to put their television or radio on or provide reading material. Limited staffing levels meant they could not provide much time for activities and spent their day ensuring people's personal care was attended to with little time for social interaction.

This was a breach of Regulation 9 (Person-centred care); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a multitude of examples of poor communication, information sharing and practices that had led to staff failing to ensure that people's needs were met and that they were cared for properly.

On the first day of our inspection we noted that one person's urinary catheter bag was virtually full but the staff had recorded that they had emptied this some two hours beforehand. We pointed out to the area manager both the inaccurate recording and the increased risk of urine infections if the catheter bag became too full. They told us this would be raised with the care staff and it would not reoccur. On the second day of our inspection we heard, in the 7am staff handover, that one person's catheter bag was full and needed to be emptied. We found no action was then taken to do this until after 7.30am. We asked staff if they had been told about the need to prioritise the emptying of catheter bags and they said this had not been discussed with them.

This was a breach of regulation 12 (Safe care and treatment); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We found that no one took ownership of the individual care records so these were not produced and updated when needed.

We found that for one person no care plan had been developed to outline the action staff were to take in relation to their identified needs such as risk of falls. No assessments were in place to address the risks of falls or to show the correlation of falls to urine infections. From our observations, various discussions with staff and our review of the records we found a person had fallen on 12 April 2016 and sustained a head injury. A GP had visited and ensured the person had not sustained an injury warranting treatment at hospital. They found the person had an infection, which contributed to them being unsteady when walking and prescribed an antibiotic as well as instructing the nurse to complete half hourly then hourly observations. There was no information in the professional visit records about this incident but we did find in the daily records that the GP had visited on 12 April 2016. But in this entry there was no mention in the notes of the GP instruction that half hourly then hourly observations were to be completed.

We observed that this information was not handed over to the next shift and all they were told was that the person had had a fall and needed to see a GP. The senior care subsequently discussed with the nurse that the person tended to fall when they had an infection and they might therefore need antibiotics. We saw the nurse call the GP. When the GP visited the home they informed the staff that they had already seen this person and asked to see the record of the observations they had requested. None of the staff were aware that these were requested and could not find the records.

The absence of appropriate care records led to staff failing to adhere to the GP's request to monitor the person hourly and them not taking appropriate action.

The assessment for one person stated they could self-administer their insulin but needed someone to take their blood sugars twice a day. However, whilst we were in the home a member of community nursing team visited to administer this medication and told us they had required this support for some time. There was no mention of the community team administering the insulin in the person's care records. This lack of records meant staff could not be clear as to why the person now needed this level of support or the actions they needed to take to support the individual.

On 27 March 2016 an agency nurse had contacted the diabetic nurse because one person's blood sugar reading was very high. In the daily records the staff recorded that the district nurses required them to take the person's blood sugar readings four-times.to check their urine and 'push' fluids on an hourly basis. At our inspection we asked for the records of the blood sugar monitoring and were told these were held in the person's care records. We could not find specific records to show the blood sugar readings. However, in the daily records it was recorded that staff had monitored the person's blood on one to three occasions each day. We asked one of the nurses about the need to monitor this person blood sugar and they were unaware that they needed to monitor the person's blood sugar. Another nurse told us the person's blood sugar needed to be checked on a morning and a night. This suggested they had failed to follow the diabetic nurse

instructions.

We found that other people had care plans in place but these had not been reviewed and for some people did not reflect their current needs. For example, we were told that one person was now able to take small quantities of food and fluid, however, their care records did not reflect this. We could not find the letter from the speech and language therapist confirming this change to the person's dietary plan.

This was a breach of Regulations 12 (Safe care and treatment) and 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that care records were inaccurate and incomplete. They did not always detail people's needs, whether they were subject to any legal constraints such as DoLS orders or how they were to be supported. We found that the assessment documents and care records gave no detail about the goals people and the staff were working towards.

From discussion with the registered provider we found they had not considered the adverse impact on people who used the service from inadequate recording of care delivery and lack of oversight of individual care needs.

This was a breach of Regulations 12 (Safe care and treatment) and 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the registered provider had developed a complaints policy and procedure which was on display in the home. The area manager told us the process they would use for investigating complaints and how they understood the complaints procedure.

However, from our review of the evidence available we found that more complaints had been made than the folder suggested. We found where complaints had been investigated there was no evidence that outcome letters had been sent or that the complainant was satisfied that their concern had been resolved. We could not be assured that all of the complaints made had been looked into or addressed.

This was a breach of Regulation 16 (Complaints) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was no registered manager. The previous registered manager had only became registered in October 2015.and had left in February 2016 Prior to that there had been no registered manager since November 2012.

It is a breach of the provider's registration condition not to have a registered manager

The registered provider told us in the provider information return they were compliant with all the Health and Social Care Act 2008 regulations. However, the area manager and placing authorities had consistently informed them that there were significant problems with care and treatment provided at the home. We found the registered provider was fully aware that the medication practices were unsafe and the competency of the agency nurses had been questioned on numerous occasions, which had led to nurses being reported to the NMC. They were also aware that in April 2015 we found them non-compliant with two regulations and yet nothing had changed in terms of the use of agency staff. Therefore we found it difficult to understand why they would state the home was compliant.

Following the inspection in April 2015 the registered provider had been asked to submit an action plan outlining the steps they were taking to achieve compliance. This had not been received.

This was a breach of Regulation 17 (3) (Good governance); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered provider was aware of the difficulties recruiting permanent nurses and that this was adversely impacting the care and treatment being delivered. However they had taken no remedial action. We found that on several occasions since December 2015 the registered provider had mentioned in multi-agency meetings that because of the staffing difficulties they could not guarantee their delivery of nursing care would meet people's needs. However, they took no action to end their provision of nursing care. Neither did they take action to skill up the care staff team so they could provide some consistency of care and lead on the care delivery to people who had personal care needs only.

From 9 February 2016 the registered provider had no clinical oversight of actual nursing care delivery available to them as the registered manager, who was a nurse, had resigned from their post. The registered provider took no action to ensure a clinical lead was in place either via a contract with an agency or the recruitment of a new permanent nurse. Irrespective of these difficulties and the substantiated allegations of neglect and harm caused by staff either employed or hired by the registered provider continued to admit new people to the service throughout this period.

We were informed that the registered provider had systems for monitoring and assessing the service. However, these systems had not assisted the area manager to identify the cause of poor practice, the gaps in the care practices or the need to make significant improvements.

The area manager felt the medication system was simple to follow but then described the persistent failures of the agency nurses to administer medicines safely. We found virtually all of the agency nurses had not followed the procedures around safe handling of medicines so errors were persistently identified. The area manager had not undertaken a comprehensive review of the medication systems to determine why this was occurring.

In July 2015 we had noted there have been significant concerns raised about care practices These had predominantly related to medication administration and nurse's competencies. We found the systems purported to be in place to monitor and improve practices at the home had not led to any changes and in fact practices at the home had become worse.

The registered provider had not reviewed their existing systems and procedures to ensure they were fit for purpose. This inaction had led to the failure to ensure the nurses were qualified and competent to meet the needs of the people who used the service. No action had been taken to draw lessons from the substantiated complaints and associated allegations of abuse. In addition, no action had been taken to ensure someone at the service took ownership or control of the delivery of safe and appropriate care and treatment to include the safe administration of medication..

In February 2016 it came to light that since December 2015 quantities of controlled drugs had gone missing from the home. This was alerted to the police and local safeguarding team who assisted the registered provider to identify the extent of the problem. However, we found no action had been taken to prevent this reoccurring and on our second visit noted that further quantities of medication had gone missing the previous day. The area manager described the home's medication procedures as simple but this was clearly not the case as there were numerous and systemic areas. We found that the area manager, had not taken action to review the medication procedures or to ensure that staff were able to use the system safely.

The registered provider had not given consideration to the risks posed to people who used the service from them not having their needs assessed appropriately and the persistent poor care practices which left people at risk of significant harm to their health, life and wellbeing.

This was a breach of Regulation 17 (Good governance), 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to provide care and treatment that was appropriate and met people who used the service needs.

The enforcement action we took:

We took enforcement action and removed the registered provider's ability to provide nutrsing care at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were treated with dignity and were not supported to be independent.

The enforcement action we took:

We took enforcement action and removed the registered provider's ability to provide nutrsing care at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure staff obtained valid consent for care and treatment and understood the requirements of the MCA.

The enforcement action we took:

We took enforcement action and removed the registered provider's ability to provide nutrsing care at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure care and treatment was provided in a safe way.

Treatment of disease, disorder or injury	

The enforcement action we took:

We issued a section 31 Notice of Decision to prevent admissions to the home which came into force on 20 April 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people who used the service were protected from abuse and improper treatment.

The enforcement action we took:

We took enforcement action and removed the registered provider's ability to provide nutrsing care at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure the hydration and nutritional needs of people were met.

The enforcement action we took:

We took enforcement action and removed the registered provider's ability to provide nutrsing care at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to establish and operate an effective complaints procedure.

The enforcement action we took:

We took enforcement action and removed the registered provider's ability to provide nutrsing care at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish effective systems and processes for assessing and monitoring the service.

The enforcement action we took:

We issued a section 31 Notice of Decision to prevent nursing care being delivered at the home which came into force on 3 May 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure recruitment procedures were safe.

The enforcement action we took:

We took enforcement action and removed the registered provider's ability to provide nutrsing care at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to deploy sufficient numbers of suitably qualified, skilled and experienced nurses at Long Meadow Care Home.

The enforcement action we took:

We issued a section 31 Notice of Decision to prevent nursing care being delivered at the home which came into force on 3 May 2016.