Morleigh Limited

Clinton House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Clinton House is a care home which offers care and support for up to 46 predominantly older people. At the time of the inspection there were 28 people living at the service. Some of these people were living with dementia. The building is a detached house over two floors with a recently added extension on the ground floor comprising of five new en suite rooms. Clinton House is part of the Morleigh Group of care homes.

The service is required to have a registered manager and there was one in place. However, the registered manager had been on maternity leave since August 2016. A temporary manager had covered the role for the first six weeks and another manager had been appointed nine days before our inspection. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We carried out this unannounced comprehensive inspection of Clinton House Nursing Home on 1 November 2016. We brought forward the planned comprehensive inspection due to concerns that had been raised with us. These concerns related to the premises and equipment, the quality of the food, lack of activities, poor care practices, staff working without the relevant recruitment checks, staff training and medicines. At this inspection we also checked to see if the service had made the required improvements identified at the inspection of 7 April 2016.

In April 2016 we found the premises and equipment were not properly maintained. We found there was hot water at 50 degrees centigrade coming from two taps in bathrooms used by people who lived at the service. At a previous inspection in February 2016 we had also found water that was too hot coming from a different tap used by people living at the service. At this inspection we found another two taps with water coming from them that was too hot. This posed an on-going risk of people scalding themselves that had not been adequately addressed by the provider, despite being asked to rectify these issues at two previous inspections.

We also found at this inspection that there was no hot water coming from sinks in the laundry room for staff to wash their hands. There were several toilets and bathrooms, used by people living at the service, with no soap or paper towels. This meant people, visitors and staff were unable to wash their hands effectively after using the toilet.

At the inspections in April 2016 we had concerns about poor recording and missing records, of the information given to staff when they started a shift. We had raised the same concerns at previous inspections in February 2016 and October 2015. This meant it was difficult to establish what information had been provided for staff at each shift change to ensure they had the right information to meet people's needs. At this inspection we were able to see records of daily handover meetings. The information in these records was basic, although staff told us they were given detailed verbal handovers. However, on the day of the inspection an agency worker asked repeatedly during the morning if they could have a handover as they did

not know what peoples' needs were. This meant the system for providing staff with information about people's needs at each shift was still not robust.

The care we saw provided to people during the inspection was often task orientated rather than in response to each person's individual needs. Care plans did not always give staff guidance about how to provide the appropriate care to meet people's needs. People were not always referred to appropriate healthcare professionals in a timely manner. This mean relevant treatment to help people was delayed. The high reliance of the service on bank and agency workers meant that people did not always receive care from staff who knew and understood their needs. There were gaps in staff training and supervision which meant staff were not fully trained or supported in their role.

Recruitment practices were not safe. Relevant employment checks, including Disclosure and Barring Service (DBS), were not completed before new staff started to care for people. The failure to complete necessary checks before allowing staff to provide care exposed people to unnecessary risk and did not protect people from the potential risk of harm from being supported by staff who were not suitable for the role. There were not always enough staff on duty to adequately meet people's needs. Staffing levels were frequently lower that the level assessed by the service as being the number of staff needed to meet people's needs. People did not always receive assistance in a timely manner. The call bell system was faulty and difficult for new staff to understand, which could cause delays in people receiving help.

The management of medicines was not robust. One person had not been given one of their prescribed medicines for three days. Records as to why this omission had occurred stated that the medicine was 'out of stock'. However, it came to light on the day of the inspection that this medicine had 'gone missing'. This meant that the person had missed three doses of their prescribed medicine and 17 tablets of Mirtazapine were unaccounted for. Records to explain this incident were inaccurate. Some people had been prescribed creams and these had not been dated upon opening and not always recorded when applied. We found creams in people's rooms that belonged to other people. This demonstrated that prescribed creams were being shared between people.

Risks were not always identified and detailed assessments of how risks could be minimised put in place. On the day of the inspection one person nearly fell out of their wheelchair while sitting unattended. We had to intervene and ask staff to assist as they had not noticed. Records for this person showed that they were at risk of falls. However, no risk assessment had been completed to give guidance for staff or to assess the risk of them being left unattended in their wheelchair. This meant staff did not have accurate information to help ensure people were not at risk of harm.

We found management and staff were not working within the principles of the MCA. Staff were not clear on who was authorised to consent on behalf of people. The service did not fully understand DoLS legislation and how it should be applied.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Clinton House Nursing Home and has been rated as Requires Improvement since the first rated inspection carried out in December 2014. The Care Quality Commission has carried out six inspections (including this one) of the service since December 2014. At each inspection there have been breaches of the regulations.

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.

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.

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. Premises and equipment were not properly maintained.

People were not always protected from risk of harm because risks were not always identified and managed. Medicines were not safely managed.

There were not always adequate numbers of staff on duty to meet people's needs. Recruitment practices were not safe. Relevant employment checks, to ensure staff were suitable to work with vulnerable people, were not carried out before new staff started to provide care for people.

Is the service effective?

Requires Improvement

The service was not effective. Some people did not receive care and treatment that met their needs.

Referrals to external health professionals were not made in a timely manner. This put people at risk of their health needs not being met.

There were gaps in staff training and supervision which meant staff were not fully trained or supported in their role.

Management did not have a clear understanding of the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not entirely caring. Staff were kind and compassionate when they spoke with people. However, social interaction between staff and people mostly occurred when staff completed tasks for people.

Care practices did not respect people's dignity, promote their independence or enhance people's well-being.

Is the service responsive?

Requires Improvement

The service was not responsive. People did not receive care and treatment that was responsive to their individual needs. The care provided to people was often task orientated rather than in response to each person's individual needs

Care plans were not personalised to reflect people's care and treatment needs. Care plans were not updated as people's needs changed.

There was a lack of meaningful activities to meet people's social and emotional needs.

Is the service well-led?

Inadequate

The service was not well-led. The provider had not adequately assessed, monitored and mitigated the risks to people living in the service.

Some people did not receive consistent or good care because systems to provide and monitor people's needs were inadequate.

Audit processes were not effective as these had failed to identify shortfalls in relation to the premises, medicines, care plans and the monitoring of people's health needs.

Clinton House Nursing 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 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 unannounced inspection took place on I November 2016. The inspection team consisted of three inspectors and a specialist advisor. The specialist advisor had a background in working in mental health services, physiotherapy and in the management of acute health care services.

We reviewed the Provider Information Record (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed information we held about the home including previous reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with three people who were able to express their views of living at the service. Not everyone was able to verbally communicate with us due to their health care needs. However, we observed care practices for six hours during the inspection. We used the Short Observational Framework Inspection (SOFI) for an additional one and a half hours. SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We also conducted a complete tour of the premises.

We spoke with seven care staff, a nurse, the clinical lead and the manager. We also spoke with two visitors. We looked at six records relating to the care of individuals, medicines records, staff training records and records relating to the running of the home. We gave feedback to the head of operations and the provider over the telephone at the end of the inspection. During a separate visit to the provider's head office on 2

November 2016, carried out by a fourth inspector, we looked at 10 staff recruitment files.

Inadequate

Is the service safe?

Our findings

Before the inspection we received information of concern that sometimes there was no hot water in the building, some rooms were cold and there was a room with a broken window. We were also informed that some wheelchairs were broken and staff did not have access to sufficient supplies of personal protection equipment such as disposable gloves and hygienic wipes.

In April 2016 we found the premises and equipment were not properly maintained. We found there was hot water at 50 degrees centigrade coming from two taps in bathrooms used by people who lived at the service. At a previous inspection in February 2016 we had also found hot water that was too hot coming from a different tap used by people living at the service. At this inspection we found another two taps with water coming from them that was too hot. This posed an on-going risk of people scalding themselves that had not been adequately addressed by the provider, despite being asked to rectify these issues at two previous inspections.

We also found at this inspection that there was no hot water coming from sinks in the laundry room for staff to wash their hands. There were two containers marked as bleach in a cupboard, which had been decanted out of their original containers. There were several toilets and bathrooms, used by people living at the service, with no soap or paper towels. This showed that the premises were not being adequately maintained and health and safety and infection control systems were not adequate.

During this inspection the premises were warm including the new wing, which had previously been found to be cooler than the rest of the building, and we did not find any broken windows. We found there were adequate supplies of gloves and wipes for staff to use. An audit of wheelchairs had been completed in October 2016 at which time 10 out of the 15 wheelchairs had been identified as needing to be repaired and these had been taken out of use. The manager was unable to tell us the timescale for when these wheelchairs would be repaired. We saw there were still some broken parts of wheelchairs and bed rails stored in corridors around the building.

At the inspection in April 2016 we had concerns about the recording of information given to staff when they started a shift. The manager at the time was unable to locate all the records and those we were given were not consistently dated. We had raised the same concerns at previous inspections in February 2016 and October 2015. This meant it was difficult to establish what information had been provided for staff at each shift change to ensure they had the right information to meet people's needs.

At this inspection we were able to see records of daily handover meetings. The information in these records was basic, although staff told us they were given more detailed verbal handovers. However, on the day of the inspection an agency nurse, who had not worked in the service before, asked repeatedly during the morning if they could have a handover because they did not know peoples' needs. This was eventually carried out but after they had been working with people for more than two hours. This meant the system for providing staff with information about people's needs at each shift was still not robust.

The management of medicines was not robust. One person had not received one of their prescribed medicines, Mirtazapine, for three days. The person's care plan did not show that they had been prescribed this medicine. Nursing notes for the person showed that on 21 October 2016 their GP had prescribed Mirtazapine and a prescription for 28 days was supplied to the service. Nursing notes on 31 October 2016 stated, "The Mirtazapine is out of stock and yesterday it wasn't administered." However, it came to light on the day of the inspection that this medicine had 'gone missing'. This meant that the person had missed three doses of their prescribed medicine and 17 tablets of Mirtazapine were unaccounted for. The records to explain this incident were inaccurate.

Some people had been prescribed creams and these had not been dated upon opening. This meant staff were not aware of the expiration of the item when the cream would no longer be safe to use. Two people had creams prescribed for other people in their rooms. This showed prescribed medicines were being shared. Staff had handwritten some medicines entries for people, on to the MAR following advice from medical staff. Two of these handwritten entries were signed but had not been witnessed by a second member of staff. This meant that there was a risk of potential errors and the systems in place did not help ensure people always received their medicines safely.

Risks were not always identified and detailed assessments of how risks could be minimised put in place. On the day of the inspection one person nearly fell out of their wheelchair while sitting unattended. We had to intervene and ask staff to assist as they had not noticed. Records for this person showed that they were at a high risk of falling. However, no risk assessment had been completed to give guidance for staff or to assess the risk of them being left unattended in their wheelchair. This meant staff did not have accurate information to help ensure people were not put at risk of harm.

There was a call bell system so people could ring for assistance from staff should they need it. Staff told us that the number that showed on the screen to alert them that someone was calling did not correspond to the correct room numbers. Staff who regularly worked in the service were familiar with which room each number displayed related to. However, staff who were new to the service could find this more difficult and this could cause delays in people receiving help.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Before the inspection we received information of concern that new staff had been allowed to work alone with vulnerable people before the required checks had been completed. At this inspection there were two new members of staff working in the service. We were told that these staff were shadowing as part of their induction and were not working unsupervised with people. However, they were not on shift in addition to the staffing levels but as part of the seven staff working that morning. Disclosure and Barring Service (DBS) checks had not been completed for these two new staff. We witnessed that these staff assisted people to eat their lunch, unsupervised, and were therefore providing care for people.

DBS checks were completed at the provider's head office. On the 2 November 2016 we visited the head office to gather information about staff start dates and the dates when DBS checks had been requested. We found that seven staff, recruited between May and September 2016, had begun working at Clinton House before DBS checks had been completed. For three new staff the DBS check was applied for on the same day they started to work and for two other staff a few days later. The checks for the remaining two staff were not applied for until over a month after their start date. This meant the provider did not have the information required in respect of all employees as specified in Schedule 3(2) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.The failure to complete necessary checks before allowing staff to

provide care exposed people to unnecessary risk and did not protect people from the potential risk of harm arising from being supported by staff who may not have been suitable for the role.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were not always enough staff on duty to adequately meet people's needs. Our observations showed that throughout our inspection there were not enough staff to respond to people's requests for help in a timely manner. On the day of the inspection there were seven care staff and one nurse on duty from 8.00am until 2.00pm and six care staff from 2.00pm until 8.00pm to meet the needs of 28 people.

As previously reported two of these members of staff were new to the service and therefore were unfamiliar with people's needs and had not received the necessary training to enable them to carry out the roles effectively. Neither of these members of staff had previously worked in the care sector. For one of them it was their fourth day working and for the other it was their fifth day working. Although both members of staff were supposed to be shadowing more experienced members of staff we saw there were periods when they were unsupervised. The deputy manager told us, "They are always in my line of sight". However, it was a busy shift and, on occasions the deputy was required to leave the immediate area where the new staff were working to attend to people's needs. We did not see any other experienced staff members shadowing these staff. In addition to these staff, the manager, a bank worker providing one-to-one support for one person and an agency nurse were also on duty.

We looked at rotas for the current week and the previous three weeks. Rotas showed that, during that four week period there had only been two days when staffing numbers were at the levels assessed by the provider as sufficient to meet people's needs. A visitor said, "There are not enough staff for the complexity of people's care needs."

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

Records showed that manual handling equipment, such as hoists and bath seats, had been serviced. There was a system of health and safety risk assessment in place. Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. There was a record of regular fire drills.

Incidents and accidents were recorded in the service. We looked at records of these and found that appropriate action had been taken and where necessary changes made to learn from the events.

Requires Improvement

Is the service effective?

Our findings

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). 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 manager showed us details of DoLS applications that had been made for seven people and these were being processed by the local authority. However, we identified another person who did not have mental capacity to agree to their plan of care. For their own safety this person had been assessed as requiring one-to-one care, 24 hours a day which was a form of restriction. No DoLS application had been submitted for this person. There was also some confusion with staff in the service as to whether or not the person had capacity to agree to this restriction. Records clearly stated that they did not have capacity and our observations confirmed it. This showed the service did not fully understand DoLS legislation and how it should be applied.

We found management and staff were not working within the principles of the MCA. The service asked people, or their advocates, to sign consent forms to agree to the care provided. Some consent forms had been signed by people's families. There was no evidence of any power of attorney in place to show that these family members could legally act on the person's behalf. This showed that staff were not clear on who was authorised to consent on behalf of people. One person, whose care plan stated they did not have capacity to make decisions about their care, had signed a consent form. This meant that the service was not clear on this person's inability to understand such a decision and sign appropriately.

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

Some people were at risk of losing weight due to having poor nutrition. Food and drink monitoring was in place for some people living at the service. We found records in bedrooms where staff had recorded what people ate and drank each day. However, these records had not been totalled or monitored to ensure the person had sufficient intake. For one person, whose records stated 'encourage fluids - 1.5 to 2 litres daily', their chart stated they had only had 20mls on some days. The nurse in charge told us the person would have had more but this had not been recorded This meant the systems in place to ensure people had sufficient fluids to help keep them well were not robust. We were not able to clearly evidence people were getting enough to drink.

Another person's care records stated that their fluid intake should be 'encouraged'. However, there was no record about how this was being achieved or monitored as no chart record was being completed.

One person's care records stated that they were very low in weight, with a Body Mass Index (BMI) score of 14, and there were concerns that their ability to swallow was diminishing. Notes in their care records, written two weeks before our visit, said that referrals should be made to a Speech and Language Therapist (SALT) and to a nutritionist. There was no evidence that any action had been taken to make these referrals. When we brought this omission to the attention of the clinical lead the referrals to SALT and a nutritionist were made on the day of our inspection. This person's records also stated that they were taking food supplements but there was no evidence that this was happening. This meant the person's health needs were not being met because of inconsistent information being recorded about their needs, a failure of staff to follow guidance in the person's care plan, and a failure to make the appropriate referrals to specialist healthcare professionals.

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

We looked at the training matrix record and found there were gaps in fire training and some staff had not had manual handling update training. However, the matrix was not up-to–date as there were staff names on it who had left the service and some new staff were not recorded. We were not assured that the matrix was a true reflection of the training position in the service. The deputy manager had a manual handling training session planned for the day of our inspection. This training session was shortened as the deputy manager had to cover care work because two care workers had phoned in sick that day.

Staff confirmed they had training but comments varied as to the effectiveness of the training. For example, some staff said they felt confident to use hoists and equipment. Other staff said that despite having had manual handling training they were unsure about using equipment. Staff had received training in challenging behaviour, yet several staff said they were not confident about how to work with some people who displayed behaviour that was challenging. This showed that feedback from staff after training was not adequately sought, to check the worker's understanding and competency. A visitor told us, "The competency of staff is variable."

Staff told us they did not receive regular supervision. Records we looked at showed supervisions were not up-to-date. This meant staff did not always have the opportunity to meet with a manager to discuss working practices and identify any training or support needs.

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

Meals were provided by way of a four weekly menu with two choices for lunch each day. People who wished to have a meal that was not on the menu were able to have an alternative. The kitchen had a list of people's likes and dislikes so people were served meals of their choice. People were asked during the morning what they wanted for lunch and some people were shown pictures to help them make their choice. On the day of the inspection one person asked for a different meal and this was provided for them. A visitor told us, "By what I can tell the food seems OK." We heard one person ask what the choice was for tea that day. When they were told "pasties or sandwiches" , they responded, "What, again?"

We were advised by an external professional, who was also visiting the service that day, that there was some out of date food in the kitchen, including some eggs. Some tuna was also found in a bag in the freezer that had been taken out of their cans and frozen without being dated. This meant it would not be possible to check how long this food had been frozen and when it would become unsafe to use. These foods were disposed of when kitchen staff were informed about it. Overall the kitchen was well stocked, although most food was from budget ranges. A relatives told us, "I've noticed the cereals are always budget brands. You get

the impression it's all done on a shoestring."

Requires Improvement

Is the service caring?

Our findings

We saw some good examples of kind and caring interactions between people and staff. People and their visitors spoke well of staff commenting, "Staff are caring, no concerns at all", "They are all good girls" and "Staff have been so much help to me." However, despite the quality of staff interactions being good, these interactions were brief and infrequent.

We saw, on numerous occasions, people calling for assistance in the lounge and staff walking past without talking to the person asking for help. Sometimes, when staff did respond they were unable to help at that time. For example, one person requested to go to the bathroom and a worker spoke to them saying that they couldn't help but 'someone will come'. We observed that the person had to wait for some time before they were assisted to the bathroom.

One person, who sat in the same place throughout the six hours we spent observing care in the lounge, was clearly happy when staff spoke with them. We saw their face lit up and they smiled broadly when a worker had a brief conversation with them. However, these interactions did not occur very often and in between these very fleeting interactions with staff the person was in a non-engaged state.

We spent one and a half hours observing care practices while sat in the corridor by some upstairs bedrooms. One person was distressed and crying for the whole of the observation period. Staff walked by three times without speaking to the person to find out if they needed anything or to comfort them.

We found the approach of some staff was very institutionalised, meaning that care practices were for the benefit of staff and largely task based. People's individual views and wishes were not always taken into account and there was little support to help people develop and maintain their independence. Staff did not encourage people to take some risk by doing things for themselves. For example, we observed that if people tried to get up staff would intervene and encourage them to sit down in case they fell. This practice appeared to be 'normal' for staff and showed that rather than helping people to get up and walk around, with whatever assistance was appropriate, people were expected to stay sitting down. One member of staff said, "People are safe, until they decide to get up and walk."

Some bedrooms did not have any identification on the doors such as a number, their name or a picture, to support people in recognising their own bedrooms. This meant it could be difficult for people living with dementia to orientate around the building independently and find their room. During our look around the premises we heard one person calling out for assistance behind the closed door of their bedroom. There was nothing on the door to indicate the room number or the name of the person. We asked a member of staff, who was walking by, the name of the person and if they might need help. The member of staff said they did not know the person's name and if they needed help they would use the call bell. The worker carried on with their tasks without checking if the person might need some assistance.

All of the above evidence shows that the service did not respect people's dignity, promote their independence or enhance people's well-being.

This contributed to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Visitors told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in their own room.

Requires Improvement

Is the service responsive?

Our findings

The care we saw provided to people during the inspection was often task orientated rather than in response to each person's individual needs. We spent six hours observing and speaking with people in the communal areas of the service. We found there was little social interaction with people from staff, apart from when staff spoke with people while carrying out a task with them.

We were advised that a member of staff was allocated to carry out activities for two hours each afternoon. Later in the afternoon of our visit staff played some music and some people sang along to this and seemed to enjoy it. Records of activities had been recorded in some people's files and these recorded activities such as, 'music in lounge' , 'cinema' and 'DVD'. This showed the range of activities was limited. Some people had played board games on some days and there had been a pumpkin carving session in October 2016. However, there were still large parts of the day when people were either in their rooms or sitting in the communal lounge without any meaningful interactions with staff. On the morning of the inspection the television was on in the lounge. However, no-one appeared to be watching this and we did not hear staff asking people if they had any preference for a particular channel or programme. One person told us they used to enjoy trips into town but these had stopped happening some time ago. A visitor said, "There is not much in the way of activities."

Care plans did not always give staff guidance about how to provide the appropriate care to meet people's needs. Staff were not always provided with accurate and current information on people's care and support needs. There was a high reliance on bank and agency workers which meant that people did not always receive care from staff who knew and understood their needs. There was also a risk that if bank or agency workers were new to the service care plans would not provide them with accurate information about people's needs. This meant there was a risk that people would receive inconsistent or inappropriate care.

We saw several examples of care plans that were inaccurate. For example, a hydration assessment had been completed for one person, which stated that because of the high score, "The person is at risk of dehydration and needs to be placed on a fluid chart". However, in the nutrition section of their care plan it read, "A normal diet and fluid intake." There was no record of the person's fluid intake being monitored. This conflicting information put the person at risk of having inconsistent and unsafe care because staff did not have accurate information about their needs.

In other care plans there appeared to be more detailed information about people's needs and wishes. Although, the wording of some instructions were not respectful or dignified However, these were not always followed by staff. For example, for one person their care plan detailed how they needed to sleep. The description was clear and read, "Sat propped up with a sponge between their knees and a cushion under their feet. Always has a jumper on in bed as they do not like their arms showing. A towel under their chin on chest as there will be night salivating." We checked the person early in the morning to see if these instructions had been carried out. While they were propped up in bed with a sponge between their knees and a cushion under their feet they were not wearing a jumper and had no towel under their chin. This showed that staff had not followed the care plan and the person's needs and wishes were not fully met.

People who wished to move into the service had their needs assessed before moving in, and from these assessments care plans were developed. We looked at the records for two people who had moved into the service at the beginning of October, four weeks before our visit. Their care plans lacked any meaningful or accurate information about their care needs or about what care had been provided during that four weeks. On the day of the inspection a healthcare professional was visiting the service to carry out an assessment for one of these people to check if the person's needs qualified them for nursing funding. We were advised by the professional that it had not been possible to complete the assessment. This was because there was, "A lack of accurate information in notes and the care plan did not accurately represent their needs." The service was asked to update the care records and the assessor would then return in four to six weeks. This showed the service did not provide adequate information to facilitate effective working with other professionals. As the care plan was inaccurate and lacked detail we could not be assured that the person's needs were being met.

For the other person, who had moved into the service at the beginning of October, their care plan lacked detail about their needs. For example, records stated, "To receive all care and to ensure [person's name] participates in directing staff to maintain their comfort." However, there was no detail about exactly what their personal care routine might be, how much the person could do for themselves and how much staff needed to do for them. We observed that this person's communication was limited. There was no information for staff to guide them in how they might support the person to 'participate in directing staff.' This indicated the care plan had not been developed with the specific needs of the person in mind. There was a risk that they might receive care that did not meet their needs because they may not be supported to communicate their wishes effectively.

This contributed to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. There had been one complaint recorded since out last inspection in June 2016. This had been made by a member of staff because there had been gaps in the recording of when medicines were administered. It was not clear what action if any had been taken about this complaint.

Inadequate

Is the service well-led?

Our findings

We have had concerns about poor recording and missing records, in relation to the information given to staff when they started a shift, at inspections in September 2016, February 2106 and April 2016. While we saw some improvements at this inspection we still had concerns about the effectiveness of the communication between staff. This meant the system for providing staff with information about people's needs at each shift was still not robust.

The service is required to have a registered manager and there was one in place. However, the registered manager had been on maternity leave since August 2016. A temporary manager had covered the role for the first six weeks and another manager had been appointed nine days before our inspection. Staff told us they felt supported by the new manager although they were very new to the post. One commented, "They will turn things around." However, staff supervision and appraisals had not been regularly carried out. The new manager was aware of this and told us they planned to meet with all staff as soon as possible. Staff told us morale was low due to the instability of the management of the service and the high use of bank workers. Rotas showed that sickness levels were high and as a result so was the use of bank workers.

There were quality assurance systems in place. Regular audits were completed for maintenance, care plans, pressure mattresses, bed rails, bath hoists, medicines, pressure sore management, falls, laundry and catering. Monthly visits to the service by the head of operations were in place to check that quality assurance systems in the service were being completed. However, these systems had not been effective in identifying the areas of concern we had found at this inspection

We have had concerns about bathrooms and toilets that had hot water coming from taps which was a scalding risk to people since February 2016. We have asked the provider to take action to rectify this issue at inspections in February 2016 and April 2016. At each inspection, while the water temperature coming from taps identified at previous inspections had been rectified, we found other taps had the same problem where they had previously had the correct temperature. This demonstrated that while the provider improved the areas we asked them to, other parts of the premises had fallen into disrepair. This meant the provider did not have effective systems to maintain the premises or have adequate oversight to ensure there was a suitable and safe environment for people to live in.

The provider had failed to improve their centralised recruitment practices despite being required to do so at two of the organisation's other care homes. At inspections at one care home owned by Morleigh Limited in January 2016 and another in April 2016 we found new staff were working before Disclosure and Barring Service (DBS) checks had been completed. As a result of these findings we met with the provider in April 2016 to discuss what action they intended to take to improve the recruitment procedures across all six of their care homes, including Clinton House. Notes from that meeting recorded that the provider told us, "New systems have been put in place and explained to all managers. New staff will not be offered the job until the first part of the DBS check has come through and will not work unsupervised until the full DBS is completed."

Despite these assurances, as detailed in the safe section of the report, we found two care staff working unsupervised in the service before their DBS had been completed. During our visit to the provider's head office we found seven other staff at this service who had started to work unsupervised before their DBS check had been completed. The provider had applied for DBS checks for five of these seven new staff after they had started work in the service. This meant that even if they were shadowed this was still contradictory to the information given to us at the meeting in April 2016 when we were told that new staff would not be offered a job until the first part of the DBS check had been completed. This showed that the provider was not willing to make the required changes to recruitment practices to comply with the regulations and ensure people were safe.

Some people did not receive consistent or good care because systems to provide and monitor people's needs were inadequate. This included systems for food and fluid charts, monitoring people's weight, updating care plans, managing medicines and ensuring there were adequate staffing levels. These inadequate systems had led to poor outcomes for some people. For example, the service had failed to take action for one person who was at high risk of malnutrition and dehydration.

We were not assured that the training staff had received to work with people who exhibited challenging behaviours, had been effective in giving staff the knowledge to care for people living at Clinton House. Several staff said they were not confident about how to work with some people who displayed behaviour that was challenging. In addition care plans were not always providing clear guidance for staff to follow. The provider had not ensured there were adequate numbers of staff on duty to meet people's needs and provide care in a way that gave people as good a quality of life as possible. Staffing levels were determined by the provider. A dependency tool was used to establish how many staff were required to meet people's needs. This showed some people had only been assessed as needing one hours care a day. This indicated people's needs were assessed solely according to their health needs with little or no consideration given to their social needs. This demonstrated systems used by the provider were not fit for purpose.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Clinton House Nursing Home and has been rated as Requires Improvement since the first rated inspection carried out in December 2014. The Care Quality Commission has carried out six inspections (including this one) of the service since December 2014. At each inspection there have been breaches of the regulations including two Warning Notices that were served because the service was failing to meet legal requirements in relation to regulation 12 (safe care and treatment). At five out of the six inspections carried out since December 2014 the service was found not to be meeting regulation 17 which relates to good governance and management of the service.

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