Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Manor Gardens

Herons Ghyll, Uckfield, TN22 4BY

Tel: 01825714400

Date of Inspection: 13 January 2014

Date of Publication: April 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✗ Action needed
Supporting workers	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Medici Healthcare Limited
Overview of the service	Manor Gardens provides accommodation and support for up to sixty four people who require nursing or personal care.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 13 January 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, were accompanied by a pharmacist and were accompanied by a specialist advisor.

What people told us and what we found

During the inspection we spoke with the manager, six care staff and nine people that used the service. Most people told us they liked living at the home. Comments included "I'm looked after well. Staff are pleasant", "There's nothing that isn't nice" and "Staff are helpful".

We found that people were given opportunities to express their views about the care and support they received. People had the opportunity to express their preferences although it was not always clear what action had been taken to accommodate them.

We found a number of concerns which related to the care and welfare of people who used the service. Care plans did not always have up to date information and did not have all the information required in order to meet people's assessed needs. We found that people were placed at risk because care plans were not always followed. There was an inconsistent approach to the management of people's complex needs which placed people at risk of harm.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines safely. We found that controlled drugs were not managed appropriately. We also identified issues in relation to the timely receipt of medication and the monitoring and use of "as required" medicines.

Care staff told us that they felt supported and that they had opportunities to discuss any issues. We found that mandatory training was provided although not all staff had received specialist training in supporting people with complex health needs and end of life care. The provider told us that this had been arranged.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. We identified concerns about the management of records in the service. Some care plans were found to

be confusing and did not hold all the information needed to support people who used the service. We also found that a number of records that related to the management of the service were inaccurate or not available at the time of our inspection.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have referred our findings to Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

We observed that people were treated with courtesy by staff and at a pace appropriate to their needs. We saw that one person was given support with personal care and that the staff member offered this discreetly and with dignity and respect. There was a picture of each person outside their room with their preferred name. This meant that new staff had information on how to address people in accordance with their preference.

The provider may like to note that one person told us that they had been referred for physiotherapy support in October 2013 due to mobility problems. This was confirmed in the care records. They said that they had not heard anything since and did not know when they were going to get physiotherapy support. This person added that they had been had been left in their room on Christmas day and was not taken downstairs to the dining room in time for lunch. They said that they were eventually taken down as staff had "Forgotten" them and when they got there the food was cold. They added that they were "In tears" because of this. This person also said that they had asked for a cordless phone in their room as they found it difficult to move around but this had "Not been sorted".

We observed that six people were in the dining area sitting in wheelchairs to eat their lunch. It was not apparent why some of these people were required to remain in their wheelchair at this time. The provider may like to note that one of these people told us that they could get themselves up and dressed independently and this was confirmed in their care plan.

People were given opportunities to express their views about the care and support they received. One person told us that they could attend resident meetings where they could give their views and feedback. We saw records which confirmed that resident meetings took place every two or three months. The last minutes available were from a meeting in September 2013. We were told by the manager that a satisfaction survey took place in November 2012. We were shown the results received from family and friends of people that used the service, however, the results received from people who lived at the home were not available at the time of inspection.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

The people we spoke with were generally positive about the care and treatment they received. Comments included "Well looked after", "Excellent care and support", "I am looked after well. However one person told us that although they didn't like to complain they were unhappy with the support provided with regard to their mobility.

We looked at the care records for eight people that used the service. Care plans varied in detail and did not always have up to date guidance on how to meet people's needs. One person's care plan had been reviewed monthly and each time was recorded as "Care plan remains relevant". The last review was on 03/01/14 but did not reflect the fact that this person now received end of life care. This meant that there were no guidelines for how they should be supported with personal, nutritional and continence care in their current condition.

We spoke with one person and observed that their legs were weeping at time of inspection. We asked them about this and they said that they normally had their leg dressings changed every two days and that they should have been re-dressed yesterday. We asked a nurse to redress them which was subsequently done. We looked at the care plan and communication record which showed that their dressings were last changed on 09/01/14 (four days prior to our inspection). Records showed that this person was admitted to Manor Gardens on 22/12/13 and their legs had been dressed every 2 days up until 05/01/13 when it was changed to every four days. The wound management plan provided no guidelines for frequency of dressing changes. We noted that on 05/01/14 a GP had been called as the person was feverish and had a weeping red leg. The lack of a consistent plan for wound management meant that care was not delivered in a way that was intended to ensure people's safety and welfare.

We identified concerns regarding the management of fluids and nutrition. We observed one person had three drinks in their room and a container of thick 'n' easy on the side. The drinks had been thickened to different consistencies and the drink in the person's hand had not been thickened at all. A relative told us that this person's drinks had to be

thickened because otherwise they coughed a lot. We asked a staff member what consistency the drinks should be at and they replied "It depends which staff have made the drink as people used different amounts." Other staff also confirmed that the thickness of this person's drinks was "Variable." We looked at this person's care plan which provided no guidance to staff about how drinks should be prepared. The lack of a consistent management plan in relation to fluid intake placed this person at risk of choking.

We identified a number of concerns in relation to people that had breathing difficulties. We observed one person in the dining room when their tracheostomy became blocked. They had a one to one carer who calmly called for support. Nursing staff attended promptly. However we noted that the suction machine was not in the dining room when needed. We asked the deputy manager about this who stated that it was desirable for a suction machine to be available in the communal areas, but that it had been taken for use on another person and not replaced. They also told us that the person had their own portable suction machine but that this had not been used since their admission on 7/1/14. Daily records showed that this person had used the suction machine on 10/01/14 due to choking and excess secretions. There was no care plan in place for breathing despite this being a primary need for this individual. This meant that there was a lack of planning to deal with foreseeable emergencies.

We identified concerns relating to the management of catheter care. One person had seven catheter changes in three months. Daily records showed this this was mostly due to the catheter becoming blocked. There was no evidence that external support and advice had been sought. This person's care plan included details of urinary catherisation and stated it should be changed every eight weeks. We looked at the care records for another person which showed that they were due to have a catheter change on 26/10/13. However, the records stated that it was not changed until 22/12/13. There was no explanation for the delay. The inconsistent approach to the management of catheters meant that people were placed at risk of receiving inappropriate care and support.

We spoke with two visiting professionals who offered support to the home in relation to nutrition and diet. They told us that they visited the home usually every three months and that at each visit they made recommendations about the support for individual people. They said that when they returned they sometimes found it difficult to find out what action had been taken and that sometimes their recommendations had not been followed. For example they had advised that one person should have a stool chart but this had not been completed regularly. Also fluid balance sheets were not always totalled correctly. They said that they were not always informed of issues relating to people's health, for example one person had lost 6.5kg but they had not been told. Also when one person needed a new connector to maintain their nutrition intake they were not informed.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We had received some concerning information regarding unsafe management of medicines. A pharmacist inspector from CQC checked medicines management in this service.

Appropriate arrangements were not in place in relation to obtaining medicine. We saw that for two people medicines were marked 'out of stock' and not administered. When asked, the manager and a nurse told us separately that newly prescribed medicine mid cycle were identified as running out of stock as they had not been added to the medicine dosage system (MDS) system. The supply of medicine was received in a four week cycle at a time in an MDS format. This was a format where medicines were prepared and labelled to be taken for each day for each time in a separate compartment. We were told that one person took responsibility for ordering medicines and because this 'out of stock' issue had been identified, the service was going to move to a different supplier who had pledged to give a quicker service relating to receiving newly prescribed medicine in MDS format. This meant that medicines were not received in a timely fashion for continuity of prescribed treatment.

Medicines were not kept safely. There were three medicine storage rooms and four locked trolleys. There was a lockable medicines storage fridge. Fridge temperatures were monitored and recorded daily and there was an air conditioning unit in the main medicine storage room to maintain a safe temperature. We found that one person managed their own medicines and had been provided with a lockable cupboard to store their own medicines in.

There is a legal requirement to store controlled drugs in a cupboard that complies with the Misuse of Drugs (Safe Custody) Regulation 1973 and its amendments. However we found that, although the controlled drugs (CD) were kept in a locked room, the cupboard was not attached to the wall. This meant that CDs were not stored securely.

We found there were two CD cupboards and two CD registers. One cupboard had been named 'JIC' which indicated 'just in case' cupboard. We found that medicines kept in this

cupboard had belonged to people who had died. There was no system to organise the two cupboards and records were difficult to check. We found one discrepancy in the records which staff were told about. This meant that medicines were not being stored safely.

We found that medicines removed from stock for disposal were locked within this room. We saw oxygen cylinders in rooms but these did not have signs to indicate that this area was a fire risk. This meant that medicines were not stored to protect people from harm associated with unsafe storage of medicines.

Appropriate arrangements were in place in relation to the recording of medicine. We looked at all the medicine administration record (MAR) charts for the current cycle. There were some gaps in records where we expected to find a signature for medicines that had been administered. An external pharmacist had recently completed an audit at this service and had made a number of recommendations. We saw an email which informed nursing staff of good practice suggestions in advance of the full medication audit. We were told that audits of medication records had taken place but had slipped recently. The last audit we were shown was from 16 November 2013.

Medicines were safely administered. We watched two nurses separately give medicines to people. The nurses used a caring manner and each person was given their medicines individually. We saw that people were asked if they wanted to take any pain relief medication. This meant people received their medicines in a safe and person centred way.

Several people were prescribed medicine to be taken only if needed. These did not have individual guidance documents for staff on how to manage these medicines. This meant that these medicines may not be given in a consistent way. Staff told us that this would be completed as the care plans were currently being updated. We saw evidence that care plans were in the process of being updated.

We saw that medicines that required regular blood tests to check or adjust doses were managed well and there was clear information from a GP by way of a fax to indicate the current dose.

Medicines were prescribed and given to people appropriately. A GP visited the service twice a week and there was a GP's communication book that allowed staff to raise any concerns about medicines with them. This meant people's health and welfare needs were met.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

Staff were not fully supported to provide safe and adequate care for people who had complex needs.

Reasons for our judgement

The staff we spoke with were positive about the support they received. One staff member told us they enjoyed working at the home and that there was a good team of staff. Another said they "Love it here" They added that the recent management changes and change of purpose of the home had been a daunting time but that they had confidence with the current management team and that things were working well. Other comments by staff included "A good team. Really good", Teamwork is fantastic" and "The manager has an open door and is supportive".

Staff told us that they received the training they needed to carry out their roles effectively. They told us that this included mandatory training such as manual handling and safeguarding. We were shown a training matrix which gave details of training received by 45 care staff and 13 nursing staff. This showed that the majority staff had received mandatory training in areas such as infection control, fire safety, moving and handling. The training matrix showed that ten staff had completed medication training over the last year, however not all staff were involved in the administration of medication. A staff member said that induction for new staff was very organised and that this took place over two weeks with a mentor.

We asked staff what preparation they received in anticipation of the complex care needs of people who used the service. Staff told us that they received specialist training such as palliative care, tracheostomy and dementia care. One staff member said that they knew end of life care training was available but had not completed it.

We noted that the training matrix showed that five members of staff had completed training in using syringe drivers in 2013 and two staff had received training in catheter care. We saw that not all staff had received training in end of life care and dysphagia. However, staff who had not completed this training had been asked to attend specialist sessions in the future.

We were shown a supervision planner by the manager which showed that staff received supervision every two or three months. One member of staff confirmed that they had formal one to one supervisions and an appraisal once a year. They added that they had

team meetings every month. The manager told us that the last team meeting was in November 2013, however the minutes of team meetings were not available at the time of inspection.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. Regulation 20(1)(a).

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We saw that records that related to people at the home, staff and the management of the service were stored in lockable cabinets and were accessible when needed.

Care plans were sometimes found to be confusing and poorly organised. One person who received end of life care had many care plans and some of the information seemed to overlap. The "Medical condition" section included information on personal care needs, however there was also a "Washing and dressing" care plan. Breathing was included in the "Tracheostomy- maintaining airway" and also in a "Difficulty in breathing" section. There was no end of life care plan. We asked a member of staff about this who was unable to locate it.

One person's documentation to record weight, blood pressure, pulse and blood sugar were all seen to be blank. Another person at risk of falls had a bodymap and wound chart to record falls and injuries. This was confusing and showed a number of wounds but not all of these were dated. It was difficult to assess which were current and which wounds were historical. This meant that some people's personal records including medical records were not accurate and fit for purpose.

We looked at one person's record of syringe driver checks at 1.20pm which showed no entries after 10am on the day of the inspection. When we checked this chart later we saw that entries had been completed for 11am, 12pm and 1pm, including a syringe driver change at 1pm. A member of staff admitted that these records had been filled in retrospectively. It was unclear if these checks had actually taken place which meant that the records could not be relied upon to be accurate and fit for purpose.

We were shown a training matrix for staff. However this was not up to date and did not reflect all the training undertaken. This record, which was relevant to the management of the service, was not accurate.

Some of the records we asked to look at were not available at the time of inspection. These included the complaints record for 2013, minutes from team meetings and quality assurance questionnaires completed by people at the home in November 2013. The manager explained that these had been sent to storage in error. This meant that not all records relating to the management of the service could be located promptly when needed.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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