Charnley House Limited

Charnley House

Inspection report

Albert Road
Hyde
Cheshire
SK14 1DH

Tel: 01613684664
Website: www.charnleyhouse.co.uk

Date of inspection visit:
08 September 2016
09 September 2016

Date of publication:
03 November 2016

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

Summary of findings

Overall summary

We inspected Charnley House on 8 and 9 September 2016 and our visit was unannounced on day one.

The service was last inspected on 30 April 2014 when no breaches of legal requirements were found.

Charnley House is situated in the Hyde area of Tameside. The home provides care, support and accommodation for up to 40 people who require personal care without nursing.

The home is a three storey detached building that has been extended to provide 38 single accommodation rooms and one double occupancy room. Communal bathrooms and toilet facilities are available throughout the home. Bedrooms are located over three floors and people have access to one large lounge, one quiet lounge, a reminiscence room and weekly hairdresser. There is one dining room with an attached conservatory. The kitchen is also attached to the dining room with a large hatch area used to serve food directly from the kitchen. The home has a separate laundry area and boiler room that are located in the cellar.

At the time of our inspection there were 34 people living at Charnley House.

The service had a registered manager in place who was registered with CQC in October 2010. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out this inspection in response to information we received from the home around a high number of falls.

We identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full report. 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.

We made one recommendation around making the home's interior decoration more conducive to people living with dementia.

People were supported by staff who were mostly kind and caring. However, we found during our inspection that people were not always treated with dignity because people did not always receive personal care in privacy.

Care plans were in place and included information around people's history and likes and dislikes. However, the associated risk assessments were not always in place or did not accurately reflect people's care needs. Inaccurate records placed people at risk of receiving inappropriate or unsafe care and support.

We found people's documentation to consent to care and treatment had been signed by family and friends, who did not have the legal right to provide this consent. This included documentation around advance care planning. There had been no best interests meetings held at the home to make decisions for people who did not have the capacity to do so. We found the registered manager was not aware of the need for lasting power of attorney (LPA) for health and welfare to enable other people to make decisions on behalf of the people living at the home.

We found that the management and administration of medicines was of concern during our inspection. We found errors in safe storage, accuracy of medication records and we were unable to ascertain if people had received the right medicines at the right time. We asked for a medication professional from the local CCG to visit the home to check that people were receiving their medicines safely.

Documentation at the home showed us that people mostly received appropriate input from health care professionals, such as district nursing and their general practitioner (GP), to ensure they received the care and support they needed. However, we also found instances where people required input from specialist services, such as the community dietician and community falls team and these had not been identified and actioned, leading to people not receiving appropriate care and support.

Staff we spoke with understood how to safeguard people and were able to demonstrate their knowledge around safeguarding procedures and how to inform the relevant authorities if they suspected anyone was at risk from harm. However, not all staff had received training and could not demonstrate an understanding of the legal safeguards around people's mental capacity and Deprivation of Liberty Safeguards (DoLS).

During our initial tour of Charnley House on the first morning of our inspection, we noted that some areas of the home required cosmetic refurbishment and we identified issues with cleanliness and infection control in a number of areas of the building.

We found that people could not easily call for assistance; call bells in communal areas were not easily accessible and did not have cord attachments. People who had a sensor box in their bedroom did not have access to a call bell, because there was only one socket which was either used for the sensor box or the call bell. Therefore people in these bedrooms were not able to call for assistance when required.

Safety and maintenance checks for building and equipment safety were in place and up to date.

During our inspection we requested the registered manager raise four safeguarding alerts with the local authority about our concerns relating to people's current care and support; specifically lack of pertinent risk assessments, dietician referrals and medication errors. We also reported our initial findings to the local authority commissioning team.

Due to our findings on the first day of our inspection the provider invoked a temporary, voluntary suspension on new admissions to the home until the issues we had identified had been resolved.

The overall rating for this service is 'Inadequate' and therefore the service is in 'Special Measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to

propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were in place; however, these did not always reflect the current care and support needs or give accurate information, for staff to follow about how to safely provide care and treatment.

We found issues with cleanliness and infection control.

We found errors in the safe management and administration of medicines.

People who had sensor boxes in their bedrooms were not able to have access to a hand held call bell and summon assistance if required.

Safe recruitment practices had not always been followed to ensure that suitable staff had been employed to care for vulnerable people.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive the necessary professional referrals for their additional care and support needs.

Required training was incomplete or not up to date for all staff members.

Written consent was not gained from people's official representative or best interests meetings held. The registered manager was not up-to-date with legal safeguards governing consent.

Staff did not have knowledge or understanding of the Deprivation of Liberty Safeguards (DoLS).

People and their relatives were complimentary around food

quality and choice. The cook was knowledgeable around the needs and preferences of people living at the home.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw that people were mostly treated in a caring and respectful way by kind staff; however, we also saw instances where people were not always treated with privacy and dignity.

People and their relatives were complimentary about the care they received from staff at the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was an activities programme and people and their relatives told us they were happy with the activities at the home.

Care plans included detailed information around people's lives, family, history and preferences.

Written communication between staff handovers was not informative or effective.

There was a complaints procedure in place and feedback had been sought from people and their relatives around their experience of the home.

Some areas of the home were in a poor condition and required refurbishment.

Is the service well-led?

Inadequate

The service was not well-led.

There was a registered manager in place at Charnley House, but they were not up-to-date with their current obligations under the terms of their registration with the CQC.

The registered manager had failed to communicate incidents of concern to the CQC as is their legal responsibility.

Quality systems were in place to monitor the quality and safety of the service; however these had not identified the issues we found during the inspection and were therefore ineffective.

Charnley House

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 9 September 2016 and day one was unannounced. The inspection was carried out by one adult social care inspector.

Before we visited the home, we checked information we held about the service including contract monitoring reports from the local authority and notifications sent to us by the provider. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service.

On this occasion, we had not recently asked the service to complete a Provider Information Return (PIR) because we carried out the inspection in response to concerns received. A PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We walked around the home and looked in all communal areas, bathrooms, the kitchen area, store rooms, medication store and the laundry in the cellar. We also looked in several people's bedrooms and the staff room.

During the two days of inspection, we reviewed a variety of documents and records. This included policies and procedures relating to the delivery of care and the administration and management of the home and staff. We looked at five people's individual care records, the administration of medicines and three staff personnel files to check for information to demonstrate safe recruitment practices. We also checked to see if training and regular supervision had taken place.

As part of the inspection process we observed how staff interacted and supported people at mealtimes, in the lounge area and throughout the home at differing times of the day. We also observed the way people

were spoken to and several instances of care delivery where staff used manual handling techniques to move people.

We spoke with four people who use the service, three relatives and one visiting professional. We also spoke with the registered manager, the home manager, two senior carers and three staff members who provided care and support to people living at Charnley House.

Inadequate

Is the service safe?

Our findings

Relatives and people we spoke with who lived at Charnley House told us they felt safe. One visitor told us they felt their relative was safe and said, "They're safe, it's the best place for them."

Staff also told us they thought people were safe living at the home. One staff member we spoke with around the level of training told us, "I would like more (training). I feel I've enough to keep people safe." Another staff member told us, "I'm trained to keep people safe."

The registered manager told us they did not use a dependency tool to determine staffing levels as this was decided on a needs basis for the home. During our inspection we found staff were mostly visible around the home and we did not have concerns regarding staffing levels during the day. Staff we spoke with felt that staffing levels were sufficient on the whole. The rotas showed three care staff covered night shifts. However, we found there was no senior on duty for four nights per week. The registered manager told us only senior care staff had received medication training to administer any medicines. Staff told us that for these four nights per week where there was no senior carer on duty; people who lived at the home did not have access to any medication from 10pm to 7.30am the next morning. We raised these concerns with the registered manager and they told us no other staff member wanted the responsibility. We asked the registered manager to take immediate steps to ensure that people living at the home had access to any required PRN (as and when required) and rescue medicines, such as those for allergies or asthma, at all times and not just three nights per week.

During our inspection we checked to see if people's care and support plans addressed the risks that were specific to individual people's care needs and how these risks were managed. We found that people had risk assessment documentation in place however; we found that not all plans were complete or reflected people's current care needs.

We reviewed one person's care plan and associated record and found they had suffered a total of eight falls in the four weeks since their admission to Charnley House. We also learned from admission information that this person was documented as being a "High Risk of Falls" and had previously broken their hip in a fall. We looked at what risk assessments and management plans were in place to mitigate risk and address their tendency to fall and found no plans had been put in place. This person's risk assessment for falls was blank.

This meant that people did not always have the necessary risk assessments in place to minimise the risk of harm during care and support. We raised both of the concerns from our findings with the registered manager who was unaware of these serious shortfalls in protecting people from harm. We also requested the registered manager raise a safeguarding alert with the local authority regarding the above instance where a person not been adequately protected from the risk of harm.

During the inspection we found that people who had sensor boxes in their bedrooms to alert staff to

movement during the night were unable to also have access to a call bell because the wall socket could only accommodate one cable. The sensor boxes were small and light weight and could easily be moved from where they were situated at the side of the bed. This created a risk of harm to people as this meant that staff may not be alerted to someone requiring urgent help or that people may be unable to summon assistance if help was needed. We raised our concerns with the registered manager and suggested they acquire cable splitters to resolve the issue.

We found at the entrance to the main lounge there was a large garden-type wrought iron gate at the top of some very steep stairs that accommodated a stairlift. The gate was unlocked and we found several slippers left on the stairs that were causing a trip hazard. We saw people trying to climb these stairs on several occasions and being brought back down by staff. One staff member told us they were concerned that someone would fall on these stairs as they were not safe.

We found that people did not have a Personal Emergency Evacuation Plan (PEEP) in place. A PEEP provides information on accessibility and means of escape for people with limited mobility or understanding and includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire.

As part of our inspection we looked at how accidents and incidents were recorded, analysed and acted upon. Accidents and incidents were recorded on specific forms kept in the home manager's office and then copies were transferred to the individual care plans. We found in one person's care plan recording sheets named "Accidents" and another named "Falls record and analysis"; however, these two forms did not match. We found nine incidents recorded on the two forms and only two dates correlated. This meant that the true extent of this person's frequency of falls was not highlighted. We did not see evidence that the analysis report information, that clearly indicated a high level of falls, was being actioned to minimise the risks to people and reduce the number of accidents and incidents. We were not given any information and did not see any evidence of further investigation into the trend or steps taken to mitigate the risk.

The above examples demonstrate a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During the inspection we looked at three staff personnel files to check that safe recruitment practices had been undertaken. We reviewed these files to check they contained information including, work history, a minimum of two references from previous employers and checks from the Disclosure and Barring Service (DBS). The DBS carries out checks and identifies to the home manager if any information is found that could mean a person may be unsuitable to work with vulnerable adults. We found two files to be in order, however, we found one staff file without these confirmed checks in place and where only one reference had been obtained, this member of staff was working unsupervised. This meant that the provider had not received satisfactory assurances and that robust and safe recruitment practices had not been followed to ensure that suitable staff had been employed to care for people who because of their circumstances may be vulnerable. In addition, the staff member did not have previous experience caring for vulnerable adults; they had not completed their induction or undergone supervised checks on their competency necessary for the work to be performed by them.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Arrangements were in place to safeguard people from potential abuse; a safeguarding policy was in place and training was provided for staff. However, training documentation showed us that 30% of staff had not

received this training. One staff member we spoke with told us they had not had training around safeguarding through the home, but were aware of the need to safeguard people and could competently tell us what this meant for people. Other staff members we spoke with were able to tell us about the different types of potential abuse and what steps they would take to report any concerns they might have. One staff member told us they would report any concerns to the registered manager. The same person told us they would report any serious concerns to the Care Quality Commission (CQC). This meant that although training was not always complete, the staff members we spoke with were aware of potential safeguarding issues and knew what steps to take if they had any concerns around people at the home.

We looked at the way in which medicines were managed at Charnley House. We found there was a relevant policy in place and systems used for stock control and medication administration. The home used a local community pharmacy to manage the stocks and deliver the medicines. The home had the required safe cabinet and recording system for storing controlled drugs (CDs); a controlled drug is a drug whose use and distribution is tightly controlled because of its risk or abuse potential for example morphine. We checked these specific CD records and found them to be in order.

Regular medicines were stored in the home manager's office and in a locked, portable medicines cabinet under the stairs at the home. Medicines should be stored in areas with temperatures below 25 degrees and be monitored daily, however we found that the medicine storage areas were not monitored for temperatures and no records were made. This meant that medications were not being stored safely as high temperatures can compromise the quality of the medicines.
Temperature checks for the medication fridge, kept in the kitchen, were monitored and within safe limits. We checked the medicines in the fridge and found them to be stored correctly.

Medicines were administered by senior care staff from the lockable medicines trolley and were recorded on the medication administration record (MAR) sheets in individual files. Only trained senior staff and management had key access to the medication trolley. We saw that a selection of the MAR sheets did not have a photograph of the person which meant there was a risk that the right person may not receive the correct medication.

During the inspection we found, after looking in one person's care plan, they were allergic to a particular antibiotic medicine. However, this important information was not documented on the persons MAR sheet and the staff member carrying out the medication round was not aware of this person's allergy. This meant there was a risk this medicine could be given to the person and cause them to suffer adverse effects.

We observed one medication round on the first day of our inspection and found that the senior carer on duty that day was in charge of administering the medicines to people in the large lounge and dining area. During this medication round we saw the senior administering the medication was interrupted on several occasions to talk to people or on occasion, they locked up the trolley to attend to matters elsewhere in the building before returning to continue the medication round. There is an increased risk of errors in medication administration when staff are frequently interrupted during the medication administration round.

We checked a sample of MARs and found discrepancies in the recordings. Two people's MAR sheets showed that they had not received their medicines as prescribed. We found one person's MAR sheets and blister packs indicated that they had not received their medicines on two consecutive evenings and one morning's medicines were still present in their dosette pack. No information had been recorded to explain why this person had missed 3 medication doses during a one week period.

Another person's MAR sheet showed us they had not received their medicines as prescribed. This person required an important anticoagulant medicine to prevent blood clots and different dosage levels needed to be administered each day. The dosages of this medicine need to be carefully monitored and controlled. We found when we reviewed their records that they had been given the medicine on one day but the amounts given had not been recorded. On two other consecutive days records indicated they had missed both doses.

We also found that the MAR sheets for the two people we reviewed, were handwritten but did not have any checks in place to ensure the information on the sheets was correct. It is good practice to see the signatures of two qualified staff to show that the recorded information was correct. There were no starting balances, no dosage amounts recorded and no photographs on either of the forms. This meant there was a risk that the dosages given may be incorrect, the information transfer may be inaccurate and the right person may not receive the right medicine.

We raised the two identified medication administration errors with the registered manager and requested they raise urgent safeguarding alerts with the local authority. We also asked them to carry out immediate checks as to whether these people had missed their medications or there had been an administration error in the recordings. The registered manager spoke to staff and told us the two people had not missed their medications and it was the recording that was inaccurate. However, because no starting balances had been recorded we were unable to accurately ascertain whether the two people had received their medicines.

No medication audits were carried out at the home to regularly check the accuracy of the medication administration. The registered manager told us they usually have an annual check from the pharmacy they use to provide people's prescriptions. However, they had changed pharmacy provider and this had not been completed recently.

The registered manager showed us documentation that referred to annual competency checks of those staff qualified to administer medication. However, these competency checks were not carried out by a more senior member of staff qualified to do so and did not include checks around the accuracy of recording. We found during our inspection that the medication administration training certificates for all staff qualified to administer the medication had expired. We brought this to the attention of the registered manager who told us they would speak to their external training company to arrange for staff to renew their training.

During the inspection, we toured the building and found communal areas within the home to be mostly clean and tidy and free from malodour. However, we also found areas of concern regarding infection control and the cleanliness of equipment and bathrooms. We found there were no lids on bins in the main toilet areas, the bathrooms were unclean and contained people's personal items, such as, toiletries, razors, slippers and part-used bars of soap. We also found items stored in bathrooms, such as, a commode bucket and footplates from wheelchairs. In the bathroom on the first floor we found a large amount of dead flies on the floor and in the bath along with several dead wasps. Around the home, we saw several people's mobility equipment, such as, walking frames and wheelchairs were unclean and had food splashes and debris.

We saw that staff did not always wear appropriate personal protective equipment (PPE) when necessary, such as, disposable aprons and gloves. We saw two occasions where staff were providing personal care to people in their bedrooms and were not wearing the necessary aprons. This meant that staff did not always follow safe infection control practices to minimise the risk of cross contamination between people who used the service. We looked in the laundry and found there was a security keypad entry system into the cellar. The laundry did not have a safe system in place to prevent cross-contamination; the dryers and washing machines were next to each other creating a risk that clean clothes could easily come into contact with

soiled items. Clothes waiting to be washed should be kept in closed bags just prior to washing; however, they were stored in open top baskets near to clean clothes. There were hand-washing facilities in the room; however, we found a part-used block of soap and one towel for all staff use. There was no access to PPE in the laundry room to protect the hands and clothes of staff and consequently caused a risk of cross contamination.

We could see from the training matrix that staff had not received specific and up-to-date training around infection control.

We found during the inspection, staff went in and out of the kitchen regularly to make drinks and snacks for people, but they did not wear a disposable apron when doing so. We spoke with the registered manager regarding this practice and disposable aprons were purchased and staff were directed to wear them when entering the kitchen.

During our inspection we found some bedrooms required refurbishment and replacement; bedding and furnishings looked worn and tired and one person's mattress was exposed and we could see there were no protectors on mattresses or pillows. This person's mattress was made of blue vinyl-type material; this appeared old, worn and was fraying at the edges. Charnley House did not carry out mattress audits to check cleanliness and suitability.

When we spoke with staff about the availability of slings, they told us that they did not use different slings for each person and they just used the one available. This practice meant that there was a risk of cross infection by using the same sling for more than one person. Each person should have a sling for their personal use. In addition to issue with infection control, slings need to be the correct size for the person to ensure safe moving and handling.

We found Charnley House was not conducting their service in line with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections Guidance.

The above examples demonstrate a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We reviewed documents that demonstrated safety checks, such as water and fire checks were carried out and general building maintenance contracts were up to date. Equipment, such as, hoisting, laundry and electrical equipment were regularly serviced.

Inadequate

Is the service effective?

Our findings

As part of our inspection, we looked at the menus and food choices available to people living at Charnley House. We spoke with the home's cook who showed us the set menu for the next five weeks. This showed options for each meal and snacks throughout the day. During our observations of the breakfast meal, we saw people being offered a choice of cereals, toast or an option of cooked items, such as, scrambled eggs. We observed different mealtimes and saw that food looked appetising and a choice was always offered. The cook was friendly and chatty with people and we could see they were knowledgeable around people's preferences. Mealtimes were a social affair and we saw people who required assistance to eat their meal received help from attentive staff at a pace to suit the person. People were given time to eat and asked if they would like some more and if they were enjoying the food.

People told us they enjoyed the food at Charnley House, one person told us, "The food is super…they will always make me something else if I want." Another person told us, "If I don't like the food they will always make me something else." One visiting relative told us their relative enjoyed the food and said, "[Name] says the food is really good."

People with certain health conditions require their food to be prepared in a specific way to ensure they can eat and swallow their food comfortably and safely. We spoke with the cook around people's nutritional needs and specific dietary requirements, for example, diabetic or blended foods. We found they were knowledgeable around people who required their food to be prepared in a certain way. They had documentation from community dieticians to refer to in the kitchen for each person, where people had received a diet plan after a referral. We spoke with the cook about people who may require their food to be fortified to add calories. In the individual care plans we reviewed we found no-one was on a fortified diet, however, the cook showed us how they used wholesome and healthy ingredients and all food was home-made in the kitchen each day. They told us they fortified all food on a daily basis by using cream and other high calorie foods to ensure the people received hearty meals on a daily basis to help keep them well.

We saw that one person living at the home looked particularly underweight and we reviewed their care plan documentation and found they required input from the community nutritionist due to weight loss and reduced food intake. We found this had not been actioned by the home. In their care plan we found nutritional risk assessments and a malnutrition universal screen tool (MUST) had been completed. This person had a BMI measurement of just 17 indicating they were underweight and required specialist input from a community dietician. A person's BMI measurement indicates if a person is within a healthy weight range and is calculated using a person's weight and height. The home's assessment MUST documentation had not been completed accurately and the person was assessed at "Medium risk", however, the correctly calculated score was "High Risk".

The home's own nutritional risk assessment was also not acted upon. The person's total risk was identified at "High risk" with a score of 16 at the time of their admission in December 2015 and a subsequent score of 19 indicating "Very high risk" from June 2016. A score of 15 or over required a specialist referral to be made

stating "Seek Dietetic Advice". Additionally, this assessment required anyone with a score over eight to have a specific nutritional care plan in place. The person did not have a nutritional care plan in place and had not had a referral to the community dietician service. This meant that despite the person's appearance showing they were underweight, weight records indicating they had lost 9 kilograms since their admission and the nutritional risk assessment results requiring specific plans and specialist input, this person's weight issues had not been addressed and no referrals had been made. Due to these findings we requested the registered manager make an immediate safeguarding referral to the local authority.

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

We spoke with staff about people's choices and gaining consent to provide care and support to people at Charnley House. Staff told us how they would give people choices around what they would like to do and that they told us they would always ask before delivering care. During our inspection we could see that staff sought consent from people before providing care and support.

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 made 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 are called the Deprivation of Liberty Safeguards (DoLS).The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We looked at whether Charnley House was working within the requirements of the MCA and DoLS and we saw that applications for some people had been made to the local authority.

We found when we spoke with staff that they did not have an understanding of the MCA or DoLS and were not able to confidently describe to us what this meant for people who lived at the home. One staff member told us they did not know what DoLs was and had not received training. We reviewed the training matrix and could see that less than 20% of staff had received training in this subject. This meant that the majority staff had the did not have the knowledge to be able to ensure that people were not deprived of their liberty without the legal safeguards in place and to ensure that care and support was always provided in line with the MCA. We spoke to the registered manager around their responsibilities to ensure that relevant people within the home needed a DoLS authorisation in place; they told us they understood that it was not required if the person had chosen to come and live at the home. These examples demonstrated a lack of knowledge and understanding and meant that people who had capacity or did not have a DoLS in place may be inadvertently being deprived of their liberty. We advised the registered manager to ensure they carry out DoLS assessments on every person living at Charnley House to see if they required an application to be sent to the local authority.

We looked in five people's care plans and saw that written consent had not been given on the relevant forms by people who were legally entitled to do so. We found relatives or friends had signed forms and on one occasion consent forms remained unsigned. We did not see evidence of mental capacity assessments where people may not have had capacity to consent to care and treatment decisions. We found no best interests meetings had been held to make decisions for the people who did not have capacity to consent to

care and treatment they were receiving. For example, we found one instance where a friend had been asked to sign the consent form for someone's advance care plan. This meant that consent to care had not been sought in accordance with the requirements of the Mental Capacity Act 2005 and associated Codes of Practice.

We spoke with the home manager and registered manager to ask if anyone living at the home had a relative with Lasting Power of Attorney (LPA) to make decisions for them around their health and welfare needs. The registered manager was aware of LPA for financial decisions, but was not aware of the legal need for a LPA for health and welfare. This meant that relatives and friends of people had consented to care and treatment for people for whom they did not have the legal right to do so.

The above examples demonstrate a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We looked at whether staff received training and the necessary support from the provider, such as, supervision and personal development, to enable them to carry out their duties competently. The registered manager told us that group supervision happened four or five times per year and if they wanted staff to know something they would put a note in with staff wage slips. They told us that full team meetings did not happen, however, a senior carer would hold team meetings every two weeks. We looked at the records for these team meetings and found they were not regular, included a small number of staff and records contained little information around what was discussed.

One of the staff members we spoke with during the inspection, told us they had not had supervision for a long time and another staff member told us they had never had supervision or an annual appraisal. We did not see any evidence of regular supervisions for staff. Despite the lack of formal supervision, staff we spoke with told us they felt supported in their role. One staff member told us, "I feel very supported; I can always be honest and open."

The management were unable to provide an up to date training matrix covering their mandatory training courses during the inspection. However, a handwritten matrix was sent through to us four days later. This showed us what training staff had undergone and indicated where the gaps were. We saw that a large number of staff had not received the company's own required level of training or had not received refresher training. This meant that people were receiving care and support from some staff members who did not have the knowledge and trained skills needed to provide care and support that reflected best practice. We looked at whether staff had specific training to meet the needs of the people at the home. For example, we found that many people living at Charnley House were living with dementia; however, we found that only 6% of staff had up-to-date dementia training. In addition, we identified that there was a high level of incidents of people experiencing a fall at the home; however, we found that staff had not received training specifically in falls awareness. An incident that happened during the inspection showed us that staff did not know how to safely monitor someone who had experienced a fall resulting in a bump to the head. This meant that there was a risk that some staff did not have the knowledge and skills needed to provide care and support to meet the needs of people at Charnley House and keep them safe.

Our concerns around the level of training extended to the quality of the training that was provided and the accreditation of the people delivering the training. The registered manager told us they used an outside training organisation to deliver manual handling, medication and fire training. However, the registered manager was unable to provide assurances on the credentials of the training provider they used. The registered manager told us they delivered the other training to staff by researching each subject, putting together a training session and asking staff to complete a subsequent question and answer sheet to assess

the competency of the trainee. However, the registered manager told us they did not have the required qualifications to deliver training.

The above examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

During this inspection we reviewed people's personal care files to check if people were supported to maintain their health and well-being. We saw that staff at Charnley House supported people to receive assistance from other health care professionals for acute intervention, such as district nurses and general practitioners (GPs). One staff member, during our site visits, escorted one person to have an x-ray at the hospital. We found that district nurses visited the home twice weekly to check and treat people who required nursing input, such as, pressure care. The district nurses had their own files kept at the home where they made their own recordings of any care interventions; these files were accessible to the home's care staff, if required. However, we found that the home did not always identify and make the appropriate referrals to other professionals to provide specialist intervention, such as, dieticians or the falls team. We saw that a podiatrist visited the home every 6 weeks to provide private treatment to residents who wished to participate.

Requires Improvement

Is the service caring?

Our findings

Throughout our inspection we saw that staff were kind and compassionate in the way they provided care and we observed instances where staff engaged with people and reassured them when providing assistance. For example, we observed one carer talking kindly and reassuringly whilst assisting a lady to stand. We also observed one carer was laughing and joking along with people whilst serving lunches in the dining room. Another carer noticed someone needed help whilst eating a sandwich and was quick to offer friendly assistance and support to the person.

Staff we spoke with told us they treated people in the way they would like to be treated themselves. They told us they liked to spend time with people and that they always took time to explain to people. We asked staff how they got to know people who lived at the home and they told us they read everything about the person; get to know their mannerisms and communication styles. They said they liked to develop relationships with the people, one carer told us, "I feel it is what I was born to do." Another carer told us they liked to make sure people were okay and were happy.

We spoke with people and their relatives about the care they received at Charnley House One person told us, "Most staff are good, it's smashing place…I've never been treated badly." Another person told us, "They look after me."

One visiting relative we spoke with told us they visited every two weeks and had no concerns, they told us, "Staff are absolutely marvellous. They go over and above the call of duty. They do a smashing job." Another relative told us they felt they had a huge weight taken off their shoulders since their relative had gone to live at Charnley House. They told us, "These people are professional. It's marvellous care. Absolutely brilliant." Another relative we spoke with told us they were made to feel welcome at the home and they were happy with the care their relative received. They told us their relative was very fond of the staff and said about them, "They're incredibly good and patient. [Name] is really good and calming. Really great. A lot of residents are really ill and they handle it very well."

One relative told us they felt that staff also looked after them and accommodated when they were visiting.

One visiting professional told us they had no issues with care at the home and had no concerns about the people who lived there as they felt any issues were dealt with in a timely way.

We asked staff how they ensured people were treated with dignity and respect during care delivery. Staff told us they would always explain to people, ask consent before providing care and ensure good communication. One staff member told us they would ensure privacy and dignity by covering people up whilst washing and providing personal care. We observed one instance where a staff member very discreetly asked someone if they would like to use the toilet by talking quietly in their ear. Visitors we spoke with told us they felt their relatives were treated with dignity and respect.

During the inspection site visits, we saw that people were mostly clean, well-groomed and had their dignity respected. However, we saw several instances where people were wearing clothes where they had spilled food or drink and they had not been assisted to change. Some people wore shoes or slippers that were not clean and some people had not been assisted to brush their hair. One person was wearing sandals that were particularly soiled with food splashes on the first day of inspection and we saw that the person was wearing the same soiled sandals on the second day of inspection. This meant that staff had assisted the person to put on the sandals in the same soiled state. We also saw this person's wheelchair was very soiled with dust and food debris and it was apparent it had not been cleaned for some time. The person's relative also commented on the unclean state of their wheelchair and told us, "This is the only thing I can fault." These examples show that staff had not always ensured that people were treated with dignity and respect with regards to their cleanliness and appearance.

We witnessed one incident on the first day of our inspection where one person had not been treated with dignity and respect during care delivery. One carer was providing personal care to a person in their bedroom with the door closed, however, the carer opened the bedroom door wide, which led to the main communal corridor and exposed the person, who was only partially clothed. People who were in the busy corridor at the time, including the inspector, were able to see the person in an undignified state in their own bedroom. The carer said to another staff member whilst the door was open, "I'm just going to get [name] a pad." This meant this person was not treated with respect regarding their privacy and dignity, and staff had not ensured that conversations about care treatment could not be overheard.

The above examples demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect

Requires Improvement

Is the service responsive?

Our findings

Each person had a document named 'Life Story' within their daily records that was kept in the office; we looked at some of these documents and found them to contain important and comprehensive information around each person. They included information around work history, where people had lived and their family connections. This meant that staff were able to get to know people they cared for and enabled them to provide care and support in a way preferred by the individual person.

There was an activities programme on the wall in reception of Charnley House displaying what was going on each week. The registered manager told us they did not have an in-house activities co-ordinator but they purchased activities from regular, external activities providers every week. We saw activities taking place at the home during our inspection; on the first day one visiting lady was providing reminiscence activities in the main lounge and this included songs. On the second day an entertainer came to provide a show in the dining room. Staff told us a fitness coach came in once per week to engage people in exercise. We also saw staff started an impromptu sing-along in the lounge during our visit; people appeared to enjoy this and sang along happily.

Staff told us they thought the entertainment at the home was very good and people enjoyed it, they said, "Activities are brilliant." One person we spoke with told us, "There's good activities, but not enough of them." Another person we spoke with told us they don't really like to join in the activities. We looked at the notice board in the main corridor and saw evidence of activities that had gone on in the past by the way of photographs taken of people participating in activities. The registered manager told us they like to take people out on trips and the home and they run a "Residents' Amenity Fund" to raise money to pay for these activities. The home benefits from a hairdressing room where one staff member provides a hairdressing service once per week.

We looked in several bedrooms and found rooms had been personalised with photographs and other personal items, such as cards to decorate the room. Rooms we looked in were clean and tidy and free from odours. . We looked at bedding in the laundry cupboard and found the sheets and quilt covers to be clean, however, they were discoloured and were wearing thin. One staff member told us there was some new bedding in another laundry cupboard on the lower ground floor, but this had not been distributed around all of the home.

We found many areas within Charnley House that required updating and refurbishment. The toilet areas and bathrooms all required redecoration and the flooring in one toilet block was damaged and in places was held down with red plastic tape. These issues were acknowledged by the registered manager during the inspection. We found one fire door on the first floor that was ill-fitting and we could see daylight around the door frame which caused a draft to blow through. The wallpaper on this first floor was also unclean in areas and peeling off the wall. We found the communal toilet area on the first floor to be locked. We asked the registered manager why these toilets were locked and they told us they should not be.

We found one communal room on the lower ground floor had been refurbished to a high standard and was known as a reminiscence room as it contained decorations and furnishings from previous decades. Staff told us this room was not used by people who lived at the home on a regular basis as people were mainly on the ground floor during the day. Apart from this room, we did not see where decoration, furnishings and signage of the home had been specifically designed to be conducive to people living with dementia. The dining room was in the process of redecoration during our inspection and we made a recommendation to the registered manager they take this opportunity to consider researching how to make the home more dementia friendly.

We looked at how people's current care needs were communicated to and between staff. We looked at people's daily recording sheets that showed what their care and support needs had been that day and night. We attended an afternoon shift handover session with staff to see how vital information about people's immediate care needs were communicated. We found that information exchange was very short and of the 34 people living at Charnley House; eight individual people were discussed. The information consisted of who had a medical/GP appointment, someone's bed being moved and someone who thought something had been taken from their room. This handover included positive feedback from the ambulance service regarding the actions of two staff members. People's moods and behaviour were not discussed. We found that the handover was a verbal exchange only and the senior carer on duty led each meeting. Short notes were made in the office diary which were used for handover and no notes of the information that had been discussed were made. This meant there was a risk of the information being lost and staff had no formal handover record to refer to during the shift or for future reference. Staff told us they were concerned around the way the handover is done; one staff member told us, "How good it is depends on the senior who is in, but I'd ask questions if I wanted to know more." Another staff member told us when discussing the handover diary, "It's not enough. There should be a list with everyone's name on."

As part of our inspection, we looked at how the home actively sought and acted on feedback from people who use the service and their relatives. The provider gave us documentation that demonstrated what they had done to ascertain how satisfied people were at the home. We reviewed feedback results collated from a resident's survey carried out in December 2015. The questions related to how satisfied people were with the service. The results indicated that most people were happy living at the home. However, the survey did not invite people to make suggestions or recommendations around how the service could be improved and we did not see how input from people had resulted in changes within the service.

There was information in the reception area of Charnley House around how to complain about the service. We saw the registered manager kept two separate files named major complaints and minor complaints and the registered manager decided themselves which file each complaint would be placed in. We reviewed the major complaints file and found few 'major complaints' were recorded. Those complaints that were recorded had been responded to in a timely way and to the satisfaction of the complainant.

People's relatives told us they always felt welcomed into the home and told us they were kept informed about their relative's care and treatment. One relative told us, "We can come anytime, always made welcome and kept informed all the time."

Inadequate

Is the service well-led?

Our findings

At the time of the inspection Charnley House had a manager in post who was registered with the Care Quality Commission (CQC).

The registered manager told us they produced a monthly newsletter for the home and told us they kept up-to-date with current guidance relevant to the local and national care sector. For example, they attended the local care home providers' meetings.

Part of a registered manager's responsibility under their registration with the CQC is to have regard to, read and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. However, we found the registered manager was not aware of their obligations to provide their service within the fundamental standards of the CQC which form part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the registered manager did not ensure they had an overview of day-to-day operations within the home and did not ensure that systems were either in place or regularly monitored to ensure a safe and effective service. There were some systems and procedures were in place at Charnley House that formed part of a quality assurance system. However, we found that these policies and procedures were not always being implemented or followed by staff to ensure the effective and safe delivery of care. For example, staff supervision was not up to date, a high number of falls had not been investigated and acted upon, risk assessments were not effective, people were not receiving their medicines in a safe way and we found issues with infection control. The registered manager did not carry out regular checks of the safety and effectiveness of the service and did not carry out assessments or checks on the competencies of their staff.

The registered manager did not have an up-to-date training matrix to allow them to keep an overview to ensure staff had suitable and up-to-date training in place in order for them to provide safe and effective care. For example, the inspector found that no staff had up-to-date medication training and the registered manager was not aware of this.

We also saw that procedures put in place to ensure safe and effective delivery of care were not being followed or completed accurately, such as, referrals to a community dietician. The management was not aware of these failings in the recordings and did not have an overview of this situation to enable suitable timely action to be taken.

We did not see evidence during our inspection to demonstrate that management had been responsive to information in order to improve the service. We did not see where feedback from relatives' and people's surveys had led to changes in the service. Information identified in the accident and incident recordings indicated that further investigations were needed to look at the high level of falls. However, we did not see evidence that this had been addressed or steps taken to reduce the incidence of falls.

Audits and checks were in place for a number of areas within the care home. Checks we reviewed included; equipment tests, fire safety and maintenance checks. Despite these checks, we found that the environment was not always clean and well maintained. We found cleanliness and safety concerns throughout the building as found during the service walk around, for example, inaccessible call bells and infection control risks in the laundry and bathroom/toilet areas. A regular, robust environmental check would have identified these areas and help minimise the risk of the potential for future incidents. This meant that although the provider had policies and processes in place, they were not operated effectively to adequately monitor the safety, quality and risk of services to people within the home.

The personal information of people who lived at the home was not kept confidential and systems did not adhere to the Data Protection Act 1998. Personal information, such as, care plans, daily records, the handover diary and risk assessments, were stored on shelves or unlocked cabinets in the open office, which meant that this private information was accessible and not kept secure. When we raised the issue of confidentiality of information in the office, the senior in charge told us they locked the door of the office when it was unattended. However, we saw numerous occasions where the office door was kept open and was unattended.

The above examples demonstrate a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Under the terms of their registration with the Care Quality Commission (CQC), providers and registered managers have a legal obligation to notify us of certain incidents, events or changes to the service. During our inspection we became aware of several safeguarding incidents at Charnley House that had not been reported to the CQC since 2015. By not notifying us of incidents such as these, we would be unable to assess if the appropriate action had been taken, the relevant people alerted and that people who use services were safe.

This was a breach of Regulation 18 (1) (2) of the Care Quality Commission (Registration) 2009.