Care Quality Commission

# Mr. Malcolm Haigh

# Anley Hall Nursing Home

**Inspection report**

Skipton Road
Settle
North Yorkshire
BD24 9JU
Tel: 01729 822268
Website: www.anleyhall.co.uk

Date of inspection visit: 3 November 2014
Date of publication: 13/01/2015

## Ratings

| Overall rating for this service | Inadequate |
|---|---|
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Inadequate |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

We inspected the home on the 3 November 2014. The visit was unannounced.

Our last inspection took place on 25 June 2014 and at that time the service was not meeting the requirements in relation to:

- the care and welfare of people using the service;
- meeting peoples nutritional needs;
- staffing arrangements;
- assessing and monitoring the quality of the service, and
- record keeping.

For example, care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. In addition to this people were not protected from the risks of inadequate nutrition and dehydration because some people, who required assistance to eat and drink, were not supported appropriately. We also found, at the inspection in June, that there were not always enough qualified, skilled and experienced staff on duty to meet people's needs; there was no effective system to assess and monitor the quality of the service and that accurate and appropriate records were not being completed.

# Summary of findings

Following our June inspection, we sent a report to the provider. An action plan was provided on 19 August 2014, from the provider, telling us what action they were taking to address the shortfalls and they would be complaint by 5 September 2013.

We found, during this visit, that the provider had not made sufficient improvements to address these matters and continued to be in breach of the regulations.

Anley Hall is registered to provide nursing care for up to 54 people, some of who may suffer from memory impairment, dementia, a physical disability or be terminally ill. The home is divided into two separate units; one is specifically used for people who are living with dementia. The home is a stone built country house, previously a private dwelling, and is situated in a rural setting on the outskirts of the market town of Settle, in the Yorkshire Dales. There are communal areas for dining and relaxation. Car parking is available in the grounds. On the day of our inspection 35 people were living in the home.

During this visit, we spoke with 17 people living at the home, four visitors, eight members of staff, and a visiting doctor. We carried out our observations in the communal areas.

The home has a manager, who at the time of our visit was absent from work and who has not yet completed a formal registration application to be registered with the commission. The provider had employed the assistance of a management company to oversee the running of the service in the manager's absence. The management company includes an operations manager and two assistants. They were present in the service from Monday to Friday and available for support and advice on the telephone during other times.

Some people living in the home had complex needs and had difficulties with verbal communication. The staff had developed different communication methods in accordance with people's needs and preferences. This approach reduced people's levels of anxiety and stress.

Although people told us they felt safe in the home we found the service was not providing consistent safe care. We found there was a reliance on agency staff to cover staff absence and staff vacancies, that care records lacked detail, were inaccurate at times and that peoples nutritional and hydration needs were not consistently being met. Despite some positive comments from the people we spoke with we found the service was not effective. People had been found to be losing weight and in some examples we saw, no action had been taken to address this, people were not regularly supported when they were at risk of developing pressure ulcers and not everyone was being supported to eat and drink despite there being a clear need for this.

We also found the home was in need of some maintenance and there were malodours in some areas of the home.

People had not been routinely involved in planning their care, some people we met during the visit were dishevelled and attention was not given to people who had food spills on clothing or around their mouths after meals.

There were no clear lines of accountability and the home did not have an effective quality assurance system in place and there was no audit schedule. We found this put people at risk of potentially unsafe or inappropriate care. This meant people were not benefiting from a service that was continually looking at how it could provide a better service for people. This contradicted the view of the staff we spoke with who told us they were keen to improve the service.

We were unable to confirm what training staff had been given as the training records were not available during or subsequent to the inspection visit. Staff we spoke with talked about the training they had received but some of this was a considerable time ago or was due for updating.

Medicines were appropriately stored and administered overall.

# Summary of findings

## 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.

People told us they felt safe at Anley Hall. However, during our inspection we found that the service was failing to provide consistent and safe care. Because of staff vacancies and absence there was a need for agency staff to be used to cover the rota. We found that care plans and associated records lacked detail, were inaccurate and that peoples nutritional and hydration needs were not always being met. This meant that people were not always receiving adequate nutrition and this put them at risk of being undernourished. We also found the home was in need of some maintenance and there were malodours in some areas of the home.

The Mental Capacity Act 2005 (MCA 2005) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a person's best interests. We saw that records varied but that some people, who were unable to consent to care and treatment and had had a mental capacity assessment completed, and in some instances best interest meetings had been organised. This told us staff were working within the principles of the MCA 2005 by doing everything to empower people to make as many decisions for themselves as they could and by recording those decisions.

There had been a significant number of safeguarding referrals to the local authority. Some of these had been reported by the provider and others were as a result of information being provided by third parties. Anley Hall was working with the local authority to address matters and this involved attendance at meetings and providing regular updates regarding the running of the service. However, the number of on-going safeguarding matters was of concern.

Medicines were appropriately stored and administered overall.

**Is the service effective?**

Inadequate

The service was not effective in meeting people's needs.

During the course of the inspection we found that although people had lost weight, little or no action had been taken to address this. We also saw that people, who needed support with their meals and drinks, were not being assisted to eat regularly or in an appropriate way. During our observations in communal areas, we saw that some people were not regularly moved despite them being at risk of developing pressure ulcers, according to their care records.

The environment was in need of improvement particularly around the areas used by people living with dementia. For example, there was little useful signage or proper use of colour to help people orientate themselves when moving around the home.

**Is the service caring?**

Inadequate

The service was not caring.

# Summary of findings

People we spoke with told us staff were kind and comments about them were positive.

Staff routines were mainly task focused. However, we noted some positive relationships between staff and those they were supporting.

People had not been routinely involved in planning their care, some people we met during the visit were dishevelled and attention was not given to people who had food spills on clothing or around their mouths after meals.

**Is the service responsive?**

**Inadequate**

The service was not responsive.

There was little signage in the service which was of particular benefit to people who were living with dementia or had cognitive impairment.

Not all care plans and associated records were up to date and did not reflect the current care needs of some people. People told us they would complain but they did not seem aware of the formal complaints procedure.

The activity organisers were about to leave the service, we did however see there was an activity programme available for those wishing to take part.

**Is the service well-led?**

**Inadequate**

The service was not well-led.

The home did not have an effective quality assurance system in place and there was no audit schedule. This meant people were not benefiting from a service that was continually looking at how it could provide a better service for people.

There was no clear leadership in the home. The manager was absent during the period of our inspection and there was a consultancy overseeing the service.

# Anley Hall Nursing Home

**Detailed findings**

## Background to this inspection

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

This was an unannounced inspection, which was carried out in one day. We visited on 3 November 2014. The inspection team consisted of four inspectors and two specialist advisors, one with a specialist role in nursing and the other with a background in governance and management. The team were also joined by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed all the information we held about the service. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made. In addition to this, before the inspection we would usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not request the PIR. However, this does not affect the inspection process, the information we requested can be gathered during an inspection visit.

We used the Short Observational Framework for Inspection (SOFI) because there were a number of people living with dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed people in the lounge and dining areas during meals and at rest. We also talked with 17people who could share their experiences, talked with four visiting relatives, spoke with eight members of staff and tracked ten peoples care from when they were admitted and looked at how their present needs were being met. We also spoke with the operations manager and an assistant, both of whom were employed by the provider to act as management consultants.

We looked at all areas of the home, including people's bedrooms (with their permission), the kitchen, laundry, bathrooms and all communal areas.

We spent time looking at other records also. This included records relating to the management of the service, for example policies and procedures, maintenance records, staff duty rosters, six staff files. We also observed a medication round, the lunchtime experience and interactions between staff and those living at the service.

Inadequate

# Is the service safe?

## Our findings

When we inspected this service on 25 June 2014, we found there were some issues with staffing levels and a high use of agency staff within the home. Although staffing levels were being monitored to ensure they remained safe, this was with a large percentage of the nursing and care staff being from agencies. There was no consistent use of the same agency staff so there was often staff who had never worked in the home before. This meant they did not know people well and did not have an opportunity to read care plans before supporting people. This could have resulted in inappropriate care being delivered.

At this visit, although the use of agency staff had reduced, we found that similar problems remained. Staff told us they did not have time to read care plans and although they were getting to know people better, they could not always rely on the information recorded as some information was contradictory. The current staffing levels, we were told by the operations manager were suitable for the numbers and dependency levels of the people living at Anley Hall. However, the operations manager was unable to demonstrate that a needs analysis or risk assessment had been carried out to determine the staffing needs for the service on any given day. When asked about how they responded to absence, which was usually short notice sickness absence, they said, "We try to cover using existing staff but usually need to ask for agency cover. This can be difficult when it isn't planned leave." We saw that on the majority of staff files they had an agreement, signed by the member of staff, that stated they would work over the prescribed limit described in Working Time Regulations. This meant that staff were working in accordance with working time legislation where they were working excessive hours.

The usual staffing arrangements were a minimum of two qualified nurses between 7.45am and 8pm and one qualified nurse between 8pm and 8am. The nurses were supported by two senior care assistants and five care assistants from 7:30am until 8:00pm. The staffing reduced to four care assistants during the night shift, with one qualified nurse and one senior care assistant. We were told by the operations manager there were still six care assistant vacancies to fill and two nurses were awaiting start dates pending satisfactory checks being made. When we checked the staff rotas we could see there were had been occasions when they had not managed to supply the 'usual staffing levels.' However, this tended to be when staff had been absent at short notice and agency staff were already working in the service and other agencies could not provide cover. One nurse, had been appointed as a clinical lead for the service, but was undergoing a 'shadowing' period before she was included on the roster. The team of ancillary staff worked seven days and there were suitable arrangements in place to make sure food provision and laundry was organised effectively.

Everyone we spoke with during the visit told us they were happy with the number of staff on duty and that they could not recall having to wait for attention if they needed it. However, when we carried out an observation in one of the communal lounges from 9:30am until 12:45pm, two people, who required full assistance with mobility and personal care, remained sitting in the same chair from being served with their breakfast and subsequently their lunch, without being taken to the toilet or having their position changed. Despite these people having pressure relieving cushions in place and being at risk of developing pressure ulcers staff had not assisted them during our observations. We asked staff why this had happened and they were unable to justify people being left in the same position without any intervention. This meant that people were at risk of developing pressure damage; this was highlighted to the operations manager at the time and action taken to resolve the situation. We asked staff about the staffing levels, they told us it had improved since two nurses were on the rota rather than one and that at times when they were short staffed they 'just managed.' One member of staff told us, "We try our best to provide good quality care, but it is hard sometimes."

The consultancy personnel, who were not included on the roster, visited the service through the week, Monday to Friday and were on call for advice out of hours and during the weekend. Suitable on call arrangement was in place and staff knew who they should contact should they need to discuss something or take advice. The owner, staff told us, was known to them and visited periodically. There was an administrator employed at Anley Hall and staff told us she was able to contact the owner readily should they wish to speak with him when he was not visiting. We found staffing arrangements were suitable for the number of people using the service but the provider needed to keep the staffing levels under constant review to make sure they staff available did not fall below an acceptable level.

Inadequate

# Is the service safe?

During this visit, we noted that some care plans did not reflect the level of support people were receiving, how needs should be met and action had not been taken to address aspects of care which could impact on the persons welfare. Inspectors also noted that some handwriting in care records and associated documentation was difficult to read and illegible because of the style of handwriting. In some cases it was difficult to understand what had been written. Much of the information, for example in daily notes, showed nothing other than if a person was asleep or awake with no indication of any meaningful engagement or social activity. Some daily activity records had not been completed since July 2014. When we asked staff if there were any other records which had not been seen and staff told us there were none. Inspectors also saw that the care plans contained basic information about people's needs and were relevant to the person's current needs. However, we did not see any extensive information regarding the care those people living with dementia required or those with related conditions. It was therefore unclear if staff were supporting people with regard to these particular needs appropriately. Daily notes were too brief and lacked detail. Information was recorded regarding basic care delivered only. There were fewer records containing details of interactions with the person, information about behaviour, mood or presentation. This meant that it was not always possible to be clear if the person was appropriately cared for and supported, as records were not complete and did not contain sufficient personal detail. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010.

On the day of our visit we looked around the premises. The home employs a full time maintenance person who was responsible for completing regular tests and maintaining areas of the home which do not require a qualified contractor. We noted that many of the records were up to date and well maintained. However, we also found multiple examples of where areas were showing signs of wear and tear or needed attention, these examples required approval from the provider and were therefore requested by the maintenance person. For example, problems were identified with some of the emergency lighting units, a fire door closure was faulty, fire exit signs were missing and some extractor fans were out of order. We found that not all windows were fitted with window restrictors. The maintenance person had reported many of the faults to the senior management team for approval but action had not been taken. We saw records confirming this. We found the external metal fire escape was slippery underfoot. This matter had been reported to the provider in 2012, no action had been taken to address the matter. All these examples demonstrate a potential risk to people using the service or working and visiting it.

With regard to décor and the fabric of the building, we found that some areas of the home were looking tatty and worn. For example, a bed base was coming away from a frame in one bedroom, a profiling bed was worn, plaster was missing in one bathroom and an electrical socket was hazardous because it was loose. This was a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010.

Some areas of the home did not smell fresh and hygiene standards were not satisfactory. We saw some carpets were stained and worn. When we spoke with the domestic staff they told us they understood their roles. We asked for the cleaning schedules and asked how they organised their work to keep the home clean and fresh. One schedule was undated and the second was dated 15 September with no year recorded and the third schedule was dated the 8 September 2014. Cleaning schedules were not specific and did not give any indication of which rooms had been cleaned or what the expectation was. For example, records stated ‘bedrooms each day’ but did not say which rooms. Cleaning routines were not being monitored showing which areas were being cleaned by whom and who had responsibility for each area. The cleaning being carried out was haphazard and did not have any routine embedded. There were no audits being carried out around infection control or hygiene standards. This was evidenced by the malodours and poor hygiene standards seen during the inspection. This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010.

When we spoke with staff, during the course of this inspection, about protecting people from harm and potential abuse they told us they would report any concerns they had about someone's welfare or safety to the manager, a senior member of staff or the owner without hesitation. Staff were able to describe the action they would take and what their expectations were if they reported anything to the senior staff. One person who used the service told us about being helped with their personal hygiene they told us they felt "safe" when staff assisted them. Another person told us they felt safe when being

Inadequate

# Is the service safe?

hoisted in and out of the bath. They said, "Staff are competent in using the equipment, I feel safe and comfortable when being lifted up." A visiting relative told us, "We visit every other day at different times, we are vigilant and we have never seen anything which caused us concern about [our relatives] safety." Staff told us they were familiar with the safeguarding policy, were using it and knew who to raise an alert with. They explained, in detail, what they would do if they suspected or saw an abusive situation and understood their responsibilities.

There was evidence the portable hoists and other items of equipment were serviced and maintained in working order.

We looked at how medicines were managed. We looked at how the service received, stored, administered, recorded and disposed of medicines. We also looked at how controlled drugs were managed. We joined a member of staff carrying out a medicine round to observe practice. The service had a medicines policy and procedure. We found that although medication rounds were lengthy, medicines management was well organised and people received their medication at the right time and in accordance with the prescriber's directions. We asked staff about how they managed medicines to be administered 'when required.' Staff were very clear about obtaining specific instructions from the prescriber and showed us evidence of when they had asked for clarity to make sure medication was given appropriately.

We had been notified of medication errors at the service over the last twelve months which related to people not receiving medication in a timely manner, incorrect administration of medication and roles and responsibilities of staff. This had also been referred to the safeguarding authority, and showed that the service was taking appropriate action when mistakes occurred.

The records which confirmed the administration of medication or application of creams and other topical preparations were completed at the time medication was given by the member of staff carrying out the task. When we checked a random sample of medicines we found these matched the expected stock being held. People we spoke with told us they received their medication at a convenient time and did not have any problems getting their medication if it was for pain or discomfort.

None of the people living at the service at the time of our visit were given their medication 'covertly'. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. Staff told us they would contact the person's doctor and work with the pharmacist if this need arose.

Medication was being stored properly and records were kept of the fridge temperature being used to store medication, which had to be kept cool and maintained at less than 5 degree centigrade. This meant that medication was being stored as instructed by the manufacturer and safe to use.

Controlled drugs, which are medicines which may be liable to misuse, were being stored appropriately. We checked the records of their use and found the required documentation was being kept, that two staff were signing when the controlled drugs were being used and the stock matched the expected amount.

Inadequate

# Is the service effective?

## Our findings

At our previous visit on 25 June 2014 we found the records relating to the nutritional needs of people were not being completed and kept. We found the same during this visit.

We reviewed care plans and associated care records to assess how well the service was meeting people's needs. One person had been identified as being at risk of weight loss and malnutrition. This person had been weighed weekly and showed a loss in weight of 16kg over an eight month period. (It was acknowledged that this person had had a hospital stay during this period and had lost some weight during that stay and that they had a pre existing condition which could have contributed to some of the weight loss.) However, a referral had been made to the dietician at the start of the recorded weight loss, but this had not been followed up or actioned since that time. The weight loss protocol being used by staff in the service showed that a trigger for dietician involvement would be a loss of 2kgs in one month or 3kgs over two consecutive months. The nutritional care plan records showed that staff had had a discussion with the doctor, following the referral to the dietician but there had been no further referral to the dietician as the person featured had been described as 'end of life.' This had been raised with the local authority by the provider.

When we inspected this service on 25 June 2014, we found there were poor arrangements in place in relation to the organisation of staff during meal times, which meant some people, were not getting the support they needed to eat in a timely manner. This was putting people at risk of malnutrition and dehydration. During this visit we again found inadequate arrangements in place and that people were losing significant amounts of weight with little action being taken to follow this up, despite referrals being made to dieticians and doctors. This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010.

During the course of this visit, observations were carried out by inspectors in the lounge and dining areas. One observation, in the dementia care unit, was carried out from breakfast time until after lunch. One person was sat in an easy chair in the lounge with an 'over bed' table in front of them with two lidded plastic cups, a bowl of porridge, and a plate with three small sandwiches. The person ate very little, licked the spoon and took tiny mouthfuls of food. The person was not assisted with breakfast. The inspector subsequently looked at the care plan relating to this person. The record stated, 'refused help.' However, the inspector saw the person still had the breakfast, taken away when their lunch was placed in front of them. It was clear the person had only managed to eat a small portion of the porridge and the sandwiches. This person also had a food and fluid chart, which was being used to monitor their food and fluid intake, due to their risk of malnutrition and dehydration. The food and fluid chart had been completed; however, the record was inaccurate and did not reflect what the person had eaten. The member of staff had made an entry to say the person had eaten all three sandwiches and the porridge, when the inspector had observed the person had only eaten one small sandwiches and little of the porridge.

The care plan relating to this person showed they were unable to express their preferences with regard to diet and drinks. However, only hot drinks and breakfast meals were recorded on the monitoring sheets with no reference to other meals taken. A dependency rating score was noted as '2' meaning this person needed minimal assistance when eating but needed staff supervision and encouragement. The person was last weighed on 15 September 2014, according to the care records seen, with no indication of how frequently they should be weighed. However, according to the policy staff were using about people being at risk of weight loss and malnutrition, there was an expectation that people would have their weights monitored on a weekly basis. This was not happening in practice.

An inspector reviewed the care plan for another person. An information sheet dated 20 September 2014 stated – '[Name of person] is on hourly food chart, needs prompting. At risk of weight loss.' The "Quality Care" review, dated 28 August 2014 showed the person was at high risk of malnutrition as they had scored a '1' and this was supported by the nutritional assessment score of '17' which again indicated – high risk. Other recorded information showed this person to have a poor appetite and they left most of their meals. The home had referred this person to the dietician. However, there was no information available to illustrate if a visit had been made or what action had then been taken thereafter. However, within the same care plan, a nutritional assessment had been completed on 21 September 2014 and repeated on 31 October 2014 but stated this person was at medium risk of malnutrition. When the inspector asked for the daily fluid and food intake

# Is the service effective?

sheets for 1, 2 and 3 November 2014, these were provided but the information was not fully completed. The person was being weighed weekly and their weight had remained steady up until August 2014 when their weight had decreased by 8kg in three months (Reducing from 66.2kg in August to 58.5kg in October 2014.) Therefore, showing that the risk had increased, but the assessment showed a decreased risk, from high to medium. Records were not accurate, were contradictory and staff could provide support and care which was not in accordance with the person's needs.

One care plan we reviewed showed that bathing and hair washing was infrequent and as an alternative body washes were given. This infrequent bathing had not been assessed and there were no apparent reasons given or risk assessment in place to explain what, if any action, staff had taken to address this matter.

During one of the observations, two inspectors noticed another person was asleep in an easy chair. An 'over bed' table was in front of the person, with a cup of tea, a bowl of porridge and jam sandwiches on it. A member of staff was asked if the person may have already eaten that morning. The member of staff said although she had not assisted the person to dress she had been told she had not had her breakfast that morning and that was why she had it in front of her at that time. During the remainder of the time in this area, inspectors observed this person had not been assisted to eat their breakfast or woken up to let them know the breakfast was still in place. The complete breakfast was taken away at lunchtime and the person had not eaten any of it or had a drink of the tea. There was no fluid or food intake chart being completed for this person according to staff spoken with. Inspectors expected that where someone is at high risk of malnutrition that the process would include their fluid and food intake being monitored by staff at all times.

We looked at the fluid and food charts for another person. Again this had not been completed correctly. There were missing dates and gaps in the recording. It was not clear how much fluid the person had received and those amounts recorded did not have a date to indicate when the fluid was offered or taken. Another inspector also witnessed a member of staff enter someone's bedroom during the afternoon, put a drink beside the person, wake them up to tell them it was there and promptly leave. She did not wait to check the person had understood or made sure she was alert enough to be able to hold the cup of tea and drink it.

One inspector was present in the dementia care unit to watch the dining experience for people using the service. She observed there were three people waiting for lunch. One person was served; the remaining people received their meal 15 minutes later. The first person said their food was warm but unappetising, they said they had not been asked what they wanted and it had been suggested to them that a menu was on the wall. There was a menu on the wall, however this referred to Sunday's lunch time choices. Despite the cook and some staff telling us that people were given a choice, it was difficult to assess if this was in accordance with people's needs, particularly those who were living with dementia. No attempts had been made to provide pictorial prompts for people or showing people what choices were available from a meal that had been plated up. The two remaining people said their meal was nice and hot. The inspector then moved to lounge area. Five people were still sitting in the same easy chairs as they had been at 10am. Three people had 'over bed' tables in front of them and were served with their lunch, which had been pureed or softened. One person's plate was so full of pureed food that when they attempted to load their spoon the food moved off the plate onto the table. Not everyone was wearing clothes protectors so food was spilling onto their tops or into their laps. We later noted that people were not assisted to change their clothing which had food spills or supported to remove dried food off their hands or faces.

We noted, breakfast and lunch, were mainly task orientated rather than a pleasurable event. However, inspectors did observe one person being assisted in a positive way.

One person, who was nursed in bed, did not receive their meal until 13:50pm. Their care plan stated they needed a food and fluid chart completing due to their risk of malnutrition. The fluid and food chart in their bedroom had not been completed for the previous 24 hours so did not record when the person had last eaten.

We judged that the dining experience varied according to how able people were to assist themselves and dependent on the deployment of staff during these peak periods. We noted that overall food appeared to be well prepared, however, not everyone, who needed assistance and

Inadequate

# Is the service effective?

support were receiving this. We saw examples of where food was removed without people being helped correctly and in some instances the person had not started their meal or drink. We also noted that records were either poorly completed or did not reflect what someone had eaten so staff, could not rely on the information provided. This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010.

There was little signage to help people with a sensory or cognitive impairment find their way around the building, apart from some people's names on their bedroom door or small signs on toilets and bathrooms. Signage, for example pictures, symbols or large print is especially useful for people who are living with dementia. There was no sensory stimulation or use of different coloured features, such as handrails and doors, to aid people with recognition and surroundings. This meant that the environment was not adapted to suit everyone's needs.

We did not see any evidence of best practice documentation or current research being used to underpin policies and procedures staff were using or were in place.

People living with dementia or other impairments can often benefit from the use of pictures or by being shown a plated meal to help them choose what they would like to eat at mealtimes. None of this was provided. A menu on the wall was not referred to by staff and we did not see people being offered a choice of meal during lunchtime.

People we spoke with during the course of the visit told us they felt well cared for by staff who had the right skills and knowledge to know what they were doing. One person described the staff as 'really good and they do their best.' Another person told us, "We get treated well; they are all friendly and kind."

We noted that staff received an induction when first starting work with the service and they told us they worked with a more experienced member of staff at first until they knew the layout of the building and the other staff. They also used the induction period as a way to get to know the people using the service. We had differing accounts from staff about the frequency of supervision and appraisals. Some staff told us they had met with a senior member of staff to discuss training needs and their individual practice. Others said they were waiting to meet with someone to carry this out. This meant that some staff had not had an opportunity to discuss their work or training needs. We asked the operations manager to provide a copy of the supervisions and training that staff had had. We asked for this during and after the inspection visit. None was provided. Staff told us about the training they had received, however, it was not possible to gain an overall view on how much training staff had been given or if their training was up to date as there was no written evidence to review.

People using the service told us they felt their health and social needs were being met. They described how a doctor would be alerted if they needed a change in medication or had a new condition or illness.

The Mental Capacity Act 2005 (MCA) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a person's best interests. We saw that records varied but that some people, who were unable to consent to care and treatment and had had a mental capacity assessment completed, and in some instances best interest meetings had been organised. This told us staff were working within the principles of the MCA by doing everything to empower people to make as many decisions for themselves as they could and by recording those decisions.

Inadequate

# Is the service caring?

## Our findings

People we spoke with could not recall having had any involvement with the writing of their care plan or the decisions about their care needs going forward. One visitor told us they had had two meetings with the staff in relation to their relative returning to the home after a stay in hospital and felt this was being handled appropriately. Many of the documents in care plans were blank and had not been completed. Personal histories were not recorded in all the care plans we looked at and staff only knew some of the histories if they had had time to ask or where the person was able to recall their previous experiences. However, we did note that some staff and people they were supporting had a good rapport and knew each other well. This meant there was minimal evidence to suggest that people received personalised care which included past and present needs.

We did not see any referrals or the involvement of advocates recorded in care records. There was no information displayed informing people of these services.

We noted that some people, in the dementia unit, looked dishevelled and following the main lunch time meal, people were not assisted to change if they had food stains on their clothing or dried food left around their mouths.

We noted a range of interactions between staff and people using the service. Some interactions could have been handled better. For example, we heard staff in the communal conservatory area discussing people's individual personal care needs openly in front of other people using the service. In one example, at 10:20am, a member of staff was supporting a person who required one to one support. A second member of staff arrived to take over and at this change over, the two members of staff loudly discussed what was needed to support the person. The second member of staff also shared their anxieties about the person's ability to swallow, saying, "I need to know because I don't want [name of person] to choke." He was referring to the need to make sure the person drank regularly and that he did not fully know the persons care needs, meaning they needed to ask several questions. Inspectors also heard staff describe individual people using inappropriate language. For example, referring to people as 'aggressive, challenging or difficult.' Staff also told each other, in communal areas, that people often had fights with each other. Everyone we spoke with told us their dignity and privacy was respected. They said staff closed doors and drew curtains when attending to their personal care needs. We saw staff knocked on people's doors before entering their bedrooms. Visitors told us they were made to feel welcome at the service and that they thought their relative was well looked after. People using the service told us that staff supported their independence and worked in a way that was unrestrictive and promoted freedom of choice. However, in complete contrast, we also noted some good interactions between staff and people they were supporting. For example we saw one person was showing signs of distress and needed assistance to use the bathroom. The carer was quick to notice this and responded promptly to the person, offering reassurance and quiet prompting so that the person knew where they was going and what support they were to receive. The carer was pleasant in her manner and quickly put the person at ease before supporting them to another area of the home.

People we spoke with during the course of our visit told us they felt well cared for. Comments included, "We are very happy with the care given here." "Staff are kind." One person referred to the changes in staff saying, "It's alright here, they [staff] sometimes vary but it's not a problem. They come if you want them but don't stop and chat." Another person told us, "No problems with the staff, they do everything I want them to do." One person said, "I feel at home here, they are very helpful and friendly, everything is absolutely perfect, and I'm very pleased."

Some people who had complex needs were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found people responded in a positive way to staff in their gestures and facial expressions. We saw staff approached people with respect and support was offered in a sensitive way. We saw people were relaxed and at ease in the company of the staff who cared for them.

We observed overall that staff spoke clearly when communicating with people and care was taken not to overload the person with too much information. This helped staff to build positive relationships with the people they were supporting. Staff were able to give us many examples of how people communicated their needs and feelings. All the staff we spoke with told us of their

Inadequate

# Is the service caring?

commitment to provide a good standard of care. Some staff acknowledged that they had strong accents but that they tried to speak slowly and clearly to help them communicate effectively with people they were supporting.

People we spoke with said they were happy with the care provided and were very positive about their relationships with staff. They also told us they felt listened to. One person told us, "Staff are really kind to me, they helped me make friends and settle in." A visitor told us their relative was looked after well and that the care was 'exceptionally good.' "The staff have a lot of patience with my relative." The person went on to say. On the whole people spoke in positive terms about the care provided. One person told us, "I like it here, they are very good."

During our inspection we spoke with members of staff who were able to explain and give examples of how they would maintain people's dignity, privacy and independence. One member of staff we spoke with said, "I try my best all the time. I won't leave anyone who needs help; I have a good work ethos."

Inadequate

# Is the service responsive?

## Our findings

We noted that some handwriting in care records and associated documentation was difficult to read because of the style of handwriting. In some cases it was difficult to understand what had been written. Much of the information, for example in daily notes, showed nothing other than if a person was asleep or awake with no indication of any meaningful engagement or social activity. Some daily activity records had not been completed since July 2014. One inspector asked staff if there were any other records which had not been seen and staff told us there were none.

Inspectors noted that although there were a variety of forms and documents in care plans, many of them were blank or poorly completed. Care plans and risk assessments were generic in content and lacked any reference to the views of the person it featured. Where there was a relative or other carer available to share information this had not been pursued. Some of the information in care plans had not been reviewed since May 2012. There were many examples of poor record keeping. For example, one care plan contained a falls risk assessment. This had been reviewed monthly and stated the person was 'confined to bed.' A member of staff told had told inspectors at the start of the inspection that the person was not nursed in bed. Many of the records and documents in care plans were blank and that the views, social interactions, personal profiles or other interactions people engaged in were not recorded but that records, when they were completed, were bland non-descript and only referred to a task that had been carried out.

The operations manager told us people were given support to make a comment or complaint where they needed assistance. They said people's complaints were fully investigated and resolved where possible to their satisfaction. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints records; however there had not been a formal complaint in the last twelve months. People we spoke with said they felt able to raise any concerns or complaints with staff but were not aware of the formal complaints procedure.

People were supported to maintain relationships with their family. On visitor told us they were kept up to date on their family member's progress by telephone, they were made welcome in the home when they visited and that they had an opportunity to talk to staff if they needed to pass on information or ask for clarity.

One person living in the home told us they were the chair of the residents association which met monthly. He said although only a few people attended it was restricted to people using the service and did not involve staff. The group had raised a complaint about the condition of the path around the home and that this had been referred to the head office and they were waiting for a response. It was clear from what was said that the group worked well and that they felt they could make suggestions and they were listened to.

One visitor told us about their involvement in their relatives care and that they had raised matters they were unhappy about with the senior staff. She said that things had improved 100% over recent times and instead of visiting daily because she was so concerned she had been happy to visit once a week.

During the visit, an inspector was told, that the activity organisers had both resigned, that the role was being reviewed and whether existing staff could take up the activities role and responsibility as part of their caring roles. Inspectors were concern that if there was no-one co-ordinating or monitoring the level of activity in the home this potentially indicated a risk that the level of activity and interaction would drop further. No indication was given as to whether this new responsibility for care staff would be supported by additional training or if the already task orientated staff would have the time to provide this additional aspect of people's overall care. During our visit we did not observe any social activities taking place. However, from the comments received from people we spoke with, there were plenty of activities on offer, these were advertised on the noticeboard in the main corridor and people told us there were weekly 'mini bus' trips to local areas and a church service on a Sunday. It was not clear if these activities would continue considering the expected staff changes and staff leaving.

Care plans were not organised in a consistent manner. One member of staff told us that she had experienced difficulty reviewing the wound management plan for a person, due to the disorderly way relevant forms were stored in the care plans. This meant new members of staff/agency staff may not have understood the care needs before supporting the

people and could have resulted in unsuitable care and assistance. The member of staff went on to explain that they had been reviewing and updating all care plans recently but that it was hard to do as they had little time whilst on duty to devote a lot of time to the task.

We were told by staff that they had received fire safety, dementia awareness and safeguarding training since July 2014. We were unable to confirm this as the training records, despite being told they would be provided, were not available during or after the inspection. This was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010

Fire fighting equipment had been serviced in the preceding twelve months and regular fire alarm checks were being carried out by the maintenance person. Fire drills had been completed in July and August 2014 and we were told another one was due to take place to include new staff and to make sure agency staff were familiar with the procedure.

Inadequate

# Is the service well-led?

## Our findings

When we inspected this service on 25 June 2014, we found there was no programme of auditing and monitoring in order to maintain safety within the environment or care delivery to ensure people were safe. There had been a large amount of injuries such as falls and there were on-going safeguarding investigations being undertaken at the time of our previous visit. At this visit we found that the monitoring of the service was not being undertaken in a way which would pick up problems and alert senior staff to issues around the running of the service. The lack of monitoring continued at this inspection.

We asked to look at audits carried out by the home and found that there was little or no auditing and monitoring taking place. There was no schedule of auditing and significant areas which impacted on people's care and wellbeing such as the environment and infection control, care plans and medication. This meant that issues around safety and health were not being identified and followed up as a way to improve the service for people. For example, we found shortfalls in the recording of care, action being taken to address health related matters and no evidence that the quality or standard of cleaning in the home was being monitored. From the evidence seen and conversations with the operations manager, it was evident that there was no clear strategy or strong leadership in the service. There were empty lever arch files or blank documents which had been put in place but not yet completed.

The arrangements in place, in the absence of the manager, were that three people, provided by a management company, were covering the home on a week day and that at all other times advice and assistance was provided over the telephone. An operations manager had overall responsibility for the home and she was assisted by two others. Their roles merged somewhat and there was little clarity of accountability. One of the consultant personnel told us, "We are fire fighting and concentrating on the important things first." When asked what this was she told the inspector that they were focusing on the 'care of people' making sure they were 'well cared for.'

During the course of the visit it was clear that paperwork and systems were disorganised and chaotic with files and papers randomly distributed in an ad hoc fashion, making it difficult to locate information quickly. Files placed on shelves were empty, but ready for the new systems of auditing to be introduced. It was acknowledged that there were plans to implement change, but the pace of change was slow and there seemed to be little or no urgency to address this matter.

Inspectors looked at a range of documentation to find evidence of auditing and quality assurance. There was none or little evidence to assure us that Anley Hall was being well led or well managed. For example, incident reporting systems were not being used effectively. This meant that opportunities for improving the care being delivered were lost, as lessons were not being learnt from incidents and accidents. This lack of an effective system to assess and monitor the quality of the service provided created risks that shortfalls would not be identified and resolved in a timely way, by either the manager or provider. This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010.

We looked at the staff rota and found that the home was strongly reliant on the use of agency staff to cover the rota, due to the number of care staff and nurse vacancies and short falls in the hours' permanent staff were able to work. The fact a significant number of staff were transient made the lack of proper records more serious and the impact on people using the service was magnified.

One of the consultancy personnel told us that there were problems with staff competency and staffing levels. The operations manager also told us that the over use of agency staff was an area of concern. There were no records to demonstrate what meetings had been held to help address the issues or what action was being taken to limit and reduce the risks associated with the poor practice being highlighted.

A member of consultancy personnel told us that, 'archiving and documentation storage has been a historic issue in the home and that they were disorganised.' When asked how this was being managed we were told that it was not a priority. Inspectors were also told that 'risk screening across all areas is to be undertaken throughout November 2014 but this has not started yet.' When asked about the day to day management of the service, the operations manager told inspectors that she would be taking on the responsibility for the day to day management of the home temporarily.

Inadequate

# Is the service well-led?

Inspectors also asked for a copy of the training matrix to satisfy themselves that staff were receiving correct training. This was said to be unavailable on the day of the visit but that it would be provided subsequently. None has been provided. Inspectors asked staff supervisions and checks on staff competencies. Inspectors were told, 'supervisions are not currently happening but it is to be addressed as soon as possible. Some people will have had one when the last management company was in place but none have been done since we came in August.'

The service had notified the Care Quality Commission, as required by law, about accidents and incidents since their last inspection.

Staff we spoke with told us they were aware of their roles and responsibilities and that they felt supported by each other. All staff spoken with told us of their commitment to provide a good quality service for people living at Anley Hall.

Staff meetings were not being held frequently. However, staff told us about the handover sessions which they found informative and they could pass on information or discuss plans for the shift.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br>**People were not protected against the risks of receiving care and treatment that was inappropriate or unsafe because the registered person had not taken proper steps to carry out an assessment of the needs of the service user; and the planning and delivery of care did not**<br>**meet the service user's individual needs.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br>**People were not protected because the provider did not have an effective operation of systems designed to regularly assess and monitor the quality of the service.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br>**People were not protected against the risks of acquiring an infection as the maintenance of appropriate standards of cleanliness and hygiene were not met.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs |

This section is primarily information for the provider

# Enforcement actions

The registered person was not protecting people from the risks of inadequate nutrition and dehydration because people were not given appropriate assistance and help to each a nutritious diet and at regular intervals.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises<br>People were not protected against the risks associated with unsafe or unsuitable premises as there were inadequate maintenance arrangements in place. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br>Peoples health, safety and welfare was not safeguarded because the registered provider had not taken appropriate steps to make sure staff employed were suitably qualified and skilled to carry out the regulated activity. |