Shaftesbury Care GRP Limited

Redworth

Inspection report

Byerley Road
Shildon
County Durham
DL4 1HQ
Tel: 01388 777311
Website:

Date of inspection visit: 24, 26 and 27 February 2015 and 4, 5 and 6 March 2015
Date of publication: 29/07/2015

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

This inspection took place over six days on 24, 26 and 27 February and 4, 5 and 6 March 2015. This was an unannounced inspection, which meant that the staff and provider did not know that we would be visiting.

Redworth provides nursing and personal care for up to 57 service users. The home is arranged over two floors. The majority of people with dementia type illness were based on the first floor of the home. During our inspection on 24, 26 and 27 February and 4, 5 and 6 March 2015 there were 28 service users at the home, 16 of whom were accommodated on the first floor.

The provider is required to have a registered manager at this home as condition of their registration. 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 found that the registered manager was no longer in post at the home. CQC records showed that the previous manager remained registered at the home even though they were no longer employed by the provider. We found

Summary of findings

the acting home manager and deputy manager had both worked at the home for approximately five months prior to our inspection. However on 4 March 2015, CQC had not received any applications for the registration of a new manager.

At our previous inspection carried out on 27,28 October and 5 November 2014 we found the home was in breach of the following:

Regulation 9, Care and welfare of service users,

Regulation 10, Assessing and Monitoring the quality of service provision,

Regulation 11, Safeguarding service users from abuse,

Regulation 12, Cleanliness and infection control,

The provider was issued with a formal Warning Notice in respect of each of these areas.

At this inspection we found that improvements had not been made to meet these requirements and Redworth was inadequate in all areas we inspected.

We looked at guidance for providers in dementia care including the following:-

- The National Institute for Care Excellence (NICE) 'Dementia Supporting people with dementia and their carer's in health and social care 2006;
- Alzheimer's Society Fact Sheet 2013. Staying Involved and Active
- The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance' and
- The NICE guidelines 'Pressure ulcers: prevention and management of pressure ulcers 2014'

The provider had failed to take account of this guidance.

We found peoples care and welfare needs were not properly met at this home. People who had dementia care needs did not have them properly met. For example people who displayed behaviours which challenged staff or other service users because of their dementia type illness were not supported by staff in a consistent or well-planned way. Detailed intervention plans for when people became agitated were not in place and best practice guidelines to help avoid these circumstances were not considered. Medicines that had a sedative effect on people were found to be used in some circumstances to manage people's behaviours, without guidance or sufficient agreed practice to safeguard and protect service users' rights.

People were at risk of poor nursing care at the home. Nurses did not demonstrate that they had an understanding of peoples nursing care needs or were taking actions to meet them. For example some people were at risk of pressure skin damage but had had their pressure relieving equipment removed. In some cases this had resulted in people developing pressure ulcers.

Some people required support with their diet so that they could remain as healthy as possible. Care planning for these people was not sufficiently detailed to protect them from being at risk and some staff supporting them lacked training and experience which also placed them at risk of harm.

There was a lack of effective person centred care for people who had dementia type illness or nursing care needs. The acting manager confirmed that no specific model of dementia care had been adopted by the provider, to guide and inform best practice for example social, psychological, or a person centred approaches. This demonstrated that the provider had failed to follow good practice guidelines issued by NICE.

We found that no therapeutic activities took place which would provide interest or stimulation and help promote positive behaviour and improve service users' wellbeing

Where people living at the home had been shown or suspected to have been subject to abuse, these had not been reported to the local safeguarding authority for consideration of investigation or to CQC for statutory notification that such an incident had occurred.

We found that people were not protected from the risk of infection. Furniture, equipment and surroundings of bedrooms and communal areas were not properly cleaned and there was poor odour control. We found that in a significant number of areas of the home appropriate standards of cleanliness and hygiene were not maintained. This demonstrated that cleaning had not been carried out effectively other procedures used at the home placed service users at risk of infection.

Summary of findings

The provider did not cooperate effectively in partnership with other providers to ensure the safety welfare and wellbeing of people at the home was upheld. Mistakes were made where people did not receive pain relief.

Medication was not administered properly so some people had their medication for serious illnesses delayed for significant periods whilst others received too much and subsequently displayed the symptoms of an overdose.

The home was not well run, operational procedures were disorganised and oversight by the provider was ineffective. The provider did not effectively assess and monitor the quality of the home to make sure it was safe, effective and meeting the homes 'Statement of Purpose'. The homes monthly audits with senior managers had not taken place since January 2015.Other areas of monitoring such as the frequency of accidents and incidents and the measures to reduce risks to people living at the home could also not be found. Other monitoring of the home had not been effective. For example, at the previous inspection we issued a warning notice about the poor cleanliness and infection control. At this inspection we found the measures to ensure the home was effectively cleaned had been unsuccessful however no monitoring had taken place and no remedial action had been taken to ensure standards of hygiene followed the prevention and control of infections Code of Practice and related guidance.

We found that the provider failed to make improvements to the quality and safety of services for people at the home. The provider did not take action following a CQC inspection on 27, 28 October and 5 November 2014 where the home was found to be in breach of four regulations and people using the service were found to be at risk despite Warning Notices being issued. The provider did not act in a timely fashion to achieve compliance, meet service users' needs and adequately protect them from receiving poor care. We found the provider remained in breach of regulations which resulted in further enforcement action to be considered.

We found there were multiple of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and under the Care Act 2014

You can see what action we took at the back of the full version of this report.

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.

We found the home was insufficiently clean to reduce the risk of the spread of infection and the provider did not have in place a robust arrangement for managing cleaning of the premises.

We found that the provider did not take measures to safeguard service users who were at risk or take appropriate steps when safeguarding incidents had occurred.

Is the service effective?

Inadequate

The service was not effective.

We found the provider failed to make sure staff maintained an accurate record in respect of each service user, which included appropriate information and documents in relation to the care and treatment provided to each person.

We found guidance issued by professional and expert bodies was not put in place at the home which placed people at risk of poor treatment and care.

Is the service caring?

Inadequate

The service was not caring.

We found some people had been administered with sedative medication without prior consideration of alternative therapeutic interventions in accordance with best practice guidance.

We found essential medication for acute pain relief was not well managed, not prioritised and did not support vulnerable service user's health and wellbeing.

We saw some people who needed support with eating were treated in a caring way with staff describing food types before giving it to them.

Is the service responsive?

Inadequate

The service was not responsive

We found there was a lack of person centred care for those people at the home who had dementia. Where people had behaviour which challenged staff, their care planning was not sufficiently robust to consistently guide staffs practice. Where care plans were in place these did not follow published guidance.

We found peoples' nursing care needs were not understood or supported at the home. People with complex conditions were not managed or routinely supported and reviewed.

We found that there were no therapeutic activities at the home which would provide interest or stimulation and help promote positive behaviour and improve service users' wellbeing.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There was no registered manager at the home and the provider did not routinely check that the service being provided there was fit for purpose and met the needs of service users.

We found the provider did not monitor or assess the service and had not ensured that people who used the service were safe, received effective care, and responsive services which met their needs.

The provider had failed to respond to CQC enforcement action. The provider did not make improvements to the quality and safety of services for people at the home in a timely fashion in order to adequately protect them from receiving poor care.

Redworth

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 was unannounced and took place on 24, 26 and 27 February 2015 and 4, 5 and 6 March 2015.

The inspection team consisted of four Adult Social Care inspectors with specialisms in older persons care and dementia.

Before this inspection we reviewed notifications that we had received from the service and a recent report from the County Durham Prevention and Infection Control Team. We also reviewed information from people who had contacted us about the service since the last inspection, for example, people who wished to compliment or had concerns about the service.

Before the inspection we obtained information from a Strategic Commissioning Manager and Commissioning Services Manager from Durham County Council, a Commissioning Manager and an Adult Safeguarding Lead Officer from Durham and Darlington Clinical Commissioning Group, Safeguarding Practice Officer and Safeguarding Lead Officer of Durham County Council, and a Lead Infection Control Nurse.

During the inspection we spoke with eight people who used the service and nine of their relatives. We had unstructured interviews with eight staff including the deputy manager and acting manager. We also spoke with the peripatetic area manager, two peripatetic nurses and the provider's head of operations. We also spent thirteen hours observing practices within the home and we also reviewed relevant records. We reviewed ten peoples' records including their care plans, risk assessment, medication information and other associated records. We looked at eight sets of recruitment records and the staff training records, as well as records relating to the management of the service.

For this inspection, the provider was not asked 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. During this inspection, we asked the provider to tell us what they were doing well.

Inadequate

Is the service safe?

Our findings

When we visited the home we found guidance issued by professional and expert bodies such as the National Institute for Care Excellence (NICE) guidance 'Dementia Supporting service users with dementia and their carers in health and social care' 2006 had not been put in place at the home. For example we found medicines that had a sedative effect on people were found to be used in some circumstances to manage people's behaviour without guidance or sufficient agreed practice to safeguard and protect service users' rights. We did not find evidence of actions staff should take to prevent people from becoming agitated or descriptions of any triggers, thresholds where medication should / should not be given or alternative techniques / strategies. The nurse in charge, acting manager and area manager agreed that these were not in place.

This is a breach of Regulation 9 (Care and welfare) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that measures to safeguard service users were not in place. During our inspection we identified that serious safeguarding incidents had not been reported to the local safeguarding authority or to the Commission. We examined the care plan records of three people all of whom were at risk of sustaining skin pressure damage. We found that appropriate steps had not been taken to protect them from risk of injury and because of this, they sustained skin pressure damage. We asked the acting manager if they could demonstrate that safeguarding alerts had been made in relation to these incidents and that the Commission had been notified. They could not confirm that these had been reported to the safeguarding local authority or CQC. This demonstrated that suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse were not in place.

This is a breach of Regulation 11 (Safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and, Regulation 18 (Notifications of other incidents), of the Health and Social Care Act 2008 Registration Regulations 2009.

We examined the homes medication administration records and daily notes where we found evidence to indicate that one service user's pain relief medication had not been administered in accordance with the prescriber's instructions. The records showed that they were at risk and had demonstrated that the symptoms of an overdose of medicines had taken place. The acting manager confirmed that the local authority had not been informed of this safeguarding incident; and neither had the Commission been notified of this matter in the form of a Statutory Notification.

This demonstrated that suitable arrangements to make sure service users were safeguarded against the risk of abuse were not in place and an appropriate response to an allegation of abuse had not been made. CQC reported this matter to the local authority safeguarding team for investigation.

This is a breach of Regulation 11 (Safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and,

Regulation 18 Notifications of other incidents), of the Health and Social Care Act 2008 Registration Regulations 2009.

We found that people were not protected from the risk of infection. We looked at all bedrooms that were in use, all bathrooms and communal areas of the home. We found in a significant number of areas of the home appropriate standards of cleanliness and hygiene in relation to the premises were not maintained. We examined six chairs in the lounges and communal areas and found them to be heavily soiled and had not been cleaned effectively. For example, there was a communal easy chair which was heavily stained with debris and dirt on the arms and a large dried spillage mark on the seat. In the dining area on the first floor of the home inside the cupboard we saw the toaster was covered in black caked on crumbs. The inside of every cupboard in this area was dirty with splashes of unknown substances and the shelves were ingrained with brown dirt. We examined five dining chairs and found in every one the seat covering and in between the spokes at the base of the seat were ingrained with food debris. Protective aprons previously used by service users had not been sent to be laundered and were stored on the window sill. This showed that these areas had not been cleaned effectively and therefore people were at risk of infection.

Inadequate

Is the service safe?

In the bedrooms that were in use we found armchairs were stained as were mattresses and the base of mattresses, with what we assessed to be blood, urine and or faeces. Some of the mattresses also had damaged bases and therefore could not be cleaned effectively. We also found some sheets and quilt covers were soiled / stained. Skin pressure relieving equipment and bed safety adaptations were not clean. In some bedrooms we found strong unpleasant odours. Bathing mobility equipment was soiled with a brown substance we assessed to be faeces.

In the Department of Health guidelines 'The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance' states in relation to criterion 2 'all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.' The observations made by us demonstrated that the home had not been cleaned effectively placing people at risk of infection and that the code of practice issued by the Department of Health in relation to infection control had not been followed.

We asked the acting manager and deputy manager if there was an infection control lead for the home. They stated that the deputy manager was now the infection control lead for the home but had only held the position for a few days. In the Department of Health guidelines 'The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance' its states that an infection prevention and control lead should be identified whose role it is to be responsible for the organisation's infection and control management and structure and be directly accountable to the registered provider'. The observations made by us in relation to the poor state of cleanliness of the environment demonstrated that the provider had failed to ensure an appropriate infection control individual was appointed placing people at risk of infection.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

At lunchtime on 5 March we checked the medicine's records and discovered that no prescribed medications, which were due to be given at 8:00 that morning, had been administered to anyone on the first floor of the home. The acting manager confirmed that the morning medicines had not been administered as they had been prescribed for all of the people living on the first floor of the home. Records showed that people had not received medicines prescribed for them for the treatment of, Alzheimer's disease, depression, high blood pressure, blood disorders requiring anti-coagulants, underactive thyroid, epilepsy, congestive heart failure, prostrate / bladder disorder and chronic pain relief. These service users were reliant on the provider to administer their medications because they lacked the capacity to safely do so themselves. CQC inspectors ensured the acting manager took immediate steps to safeguard service users. This demonstrated that you had failed to protect service users against the risks associated with the unsafe use and management of medicines.

This is a breach of Regulation 13 (Management of Medicines), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the acting home manager for any accident and incident monitoring information. The acting manager was unable to produce recent information or documents which showed that when accidents and incidents occurred, the details and circumstances were examined to make sure that any lessons learned were used to prevent future occurrences. This meant that the provider had failed to establish if people were at risk of accidental injury, failed to identify any trends or put in measures to reduce risks to people living at the home.

This is a breach of Regulation 10 (Assessing and monitoring the service) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Two relatives we spoke with commented positively. Referring to the standards of cleanliness one person said, "I know the home is under the spotlight and frankly it needs to be." Another commented, "Some areas need to be improved."

Inadequate

Is the service effective?

Our findings

The acting manager told us that the home caters for people who have dementia type illness. However we found no evidence that best practice guidance such as the National Institute for Health and Care Excellence (NICE) guidance 'Dementia Supporting people with dementia and their carer's in health and social care 2006' had been put into practice. For example: We examined the care record for one person. We saw it had been recorded that this person may present with behaviours which challenged staff due to their dementia care needs. However there was not a detailed plan or step by step guidance to inform staff and promote their skills and knowledge about what they should do to support this person in a positive way to help avoid this behaviour or what to do when they exhibited this behaviour in order to minimise the risks of escalation. There was no acknowledgement in the care plan that this behaviour was due to this person's dementia nor did the care plan acknowledge their individual needs, background, life history and circumstances which would have helped to ensure staff had enough knowledge about this person. This person's care planning did not demonstrate that care planning was being adopted in accordance with best practice guidelines. The acting manager was unable to demonstrate how NICE best practice guidance or any other guidance had been followed.

This is a breach of Regulation 9 (Care and welfare) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We examined the care records for one person who needed support from staff to eat and drink. Their 'Alzheimer's Society' assessment stated they had 'swallowing difficulties' and needed to have 'food pureed.' They also had a document entitled 'Mental Capacity Act 2005 assessment' which stated they were to be 'fully awake and alert and sat up in the upright position for feeding,' 'consulted re dietary preference,' 'allowed to swallow each mouthful before another is given' and 'needs pureed foods and thickened fluids.' Evaluation records were completed by staff to record the appropriateness of the care given and to record any further changes to their support for 'Nutrition and Hydration.' These stated that this person continued to 'require the assistance of one member of staff for all (their) feeding/drinking needs' and 'a pureed diet and thickened fluids to a custard like consistency'. Despite having these needs and entries made at various parts of their care plan, the care plan entitled 'Diet and Hydration' and their risk assessment called 'Diet and Hydration' made no reference whatsoever to this person being at risk of choking and aspiration.

We saw a member of staff who had been at the home for a short period of time supporting this person with their meal. The acting manager agreed that the new member of staff did not have the skills, knowledge and experience to support this person with their diet and had undertaken their support in error.

This is a breach of Regulation 14 (Meeting nutritional needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that the physical environment throughout the home did not reflect best practice in dementia care. The NICE Guidelines 'Dementia: Supporting people with dementia and their carers in health and social care 2006' states,

'Built environments should be enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment'.

Other than the pictures of toilets suspended from the ceiling there was no evidence of adaptations to the environment to show good practice guidelines had been put into practice. For example, there was little evidence of contrasting colours being used to aid independence, for instance on light switches, grab rails and toilet seats. We asked the acting manager what model of dementia care had been adopted by the provider, for example social, psychological, or a person centred approach to dementia care. They confirmed that no specific model of dementia care had been used in the care home to guide and inform best practice. This demonstrated that the provider had failed to follow good practice guidelines issued by NICE, the non-departmental public body with the responsibility to develop guidance and set quality standards for social care.

This is a breach of Regulation 15 (Safety and suitability of premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

From the training records we saw that staff had been provided or were planning to undertake training including

Inadequate

Is the service effective?

equality and diversity, health and safety, dementia care, safeguarding adults, fire safety and national vocational qualifications (NVQ) level two in care. We saw that some staff had training in relation to the needs of people with dementia and in relation to the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (Dols) and other training was planned. The acting manager told us they had now reviewed each member of staff's training records and that a plan was in place to ensure all staff received up-to-date training relevant to their roles. We saw records to show staff had started to receive supervision and appraisals to enable them to identify their training needs.

Two care staff told us they always worked on the dementia care unit, they told us they knew and understood people's needs well. However, they were aware that people's real needs were not recorded in their care plans. They told us this was because the care plans were completed by nursing staff who were not involved with the hands on care of people, and they did not know people's real needs or how to manage people's behaviours. The two care staff said they were rarely asked about people's needs or involved in people's care plans.

We did receive some positive feedback about staff from visitors and relatives. One service user told us, "I like the food, there is always plenty of options". Another told us, "The food is good."

Inadequate

Is the service caring?

Our findings

During the inspection we spent time with people in the communal lounge areas and dining rooms. We saw that some staff were attentive, showed compassion, were patient and interacted well with people. However other staff rarely spoke with people who used the service and limited their interactions to giving directions to people who used the service. We saw that when people became anxious some staff intervened in very supportive ways and used techniques such as going to quieter areas of the home. Whereas other staff did not appear to notice or ignored people.

We saw one person's care plans which described their needs as 'Description of Potential Hazard,' which stated, 'History of anxiety, aggression. Can assault staff and peers.' However there was no further information in the care plan which indicated that staff had sought to, or actually identified triggers so that measures could be put in place to minimise the risk of this happening. There was no detailed description as to how they may exhibit their agitation or a step by step instruction to inform staff of the best way to support this person at such times. The care plan evaluation indicated that sedative medications had been used and their dosage had been doubled because 'agitation is extreme.' There was no further information in the risk assessment, care plan or care plan evaluation of what step by step actions staff should take to support this person from becoming agitated or keep them and others safe nor was there any information about past or present triggers to this behaviour. There were no stated thresholds which would guide staff as to when sedative medication should or should not be administered; nor were there details, suggestions or work to identify alternative techniques or strategies to help avoid incidents and promote their wellbeing. There were no records that safeguards were in place to protect this person's dignity and independence nor was there any indication that an independent advocate or other representation had been considered or utilised.

The NICE Guidelines 'Dementia: Supporting people with dementia and their carers in health and social care' 2006 states: 'People with dementia who develop non-cognitive symptoms or behaviour that challenges should be offered a pharmacological intervention in the first instance only if they are severely distressed or there is an immediate risk of harm to the person or others. The assessment and care-planning approach, which includes behavioural management, should be followed as soon as possible'. Our observations and discussions with staff showed these guidelines were not being followed.

This is a breach of Regulation 9 (Care and welfare) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the records of one person who had displayed behaviours which had challenged staff on three occasions during meal times. Other records showed that they were awaiting an appointment at the dentist for the remedy of toothache. It was recorded, 'Ran out of paracetamol, still complaining of toothache and waiting for Dental Appt.' However there was no recognition in the care records that the persons challenging behaviour could be attributed to toothache, for which they had not received any pain relieve for at least three days. This showed that staffs response to this person's wellbeing had not been carried out in a caring and responsive way.

This is a breach of Regulation 24 (Cooperating with other providers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed a lunchtime period and found people who needed support with eating were treated in a caring way. One member of staff talked with a person throughout their main course and told them what was on their spoon before giving it to them.

Inadequate

Is the service responsive?

Our findings

There was a lack of person centred care for people who had dementia type illness or nursing care needs. (Person centred means written in a way to describe in an individualised way the best way to support each person taking into account their individual choices, preferences and life histories).

We saw there was a failure to provide people with meaningful activities. We found that no therapeutic activities took place which would provide interest or stimulation and help promote positive behaviour and improve service users' wellbeing. We spoke with one person who told us they used to be very active and liked to be out in the fresh air. They said, "I'm not free. I walk up and down. It's all restricted. I've always had animals. I'm used to being able to open my door, get out and get fresh air." We spoke with their visitor who confirmed that at present their relative did not regularly get fresh air or be able to get access to outside space and was consequently very unhappy. We looked at their care plan and found in the section entitled 'Things that worry or upset me:' was the statement, 'Not being able to get out into the fresh air or be able to retire."

The National Institute for Care Excellence (NICE) guidance 'Dementia Supporting people with dementia and their carers' in health and social care 2006' states, 'Health and social care staff who care for people with dementia should identify, monitor and address environmental, physical health and psychosocial factors that may increase the likelihood of behaviour that challenges, especially violence and aggression, and the risk of harm to self or others. These factors include lack of activities'.

We saw that a care plan had been written for this person called 'Activities' with a 'care intervention' that stated 'In order to make sure that any activities you are invited to take part in are suitable for you and that they will not cause discomfort or distress, we have sent a questionnaire to the closest person to you. This asks about things you used to do before you came to Redworth and any hobbies or interests that you have. Once we have this we can sit with you and discuss what things you would like to do.' However there was no further information in the care plan to describe what this persons previous lifestyle, activities or hobbies actually were. We saw two evaluations for the 'Activities care plan" which stated 'New activities care plan has now commenced' and '[Name] activities care plan should remain intact as it is still valid.' However there was no further information to describe what this person's lifestyle, hobbies or interests actually were or how they were supported at the home.

We looked at care planning records which showed they were not sufficiently detailed to consistently guide staffs practice and were not updated in response to incidents or changes in service users' condition. We looked at the assessment or care plan documents for four service users some of whom were noted by staff to display behaviour which they found challenging. We found these did not provide any guidance to staff around how to manage the challenge and deal with any episodes of aggression; and records had not been updated to show that staff had learned from incidents or revised their approaches afterwards. For example we saw one person's care plan which stated that the person was likely to challenge staff. However there was also no acknowledgement in the care plan that this behaviour was due to this person's dementia. The care plan had not been updated following the previous two care plan reviews carried out two months previously where it had been identified that their behaviour was triggered by personal interventions. There was no acknowledgement in the care plan of anxiety or depression or strategies or step by step interventions to be implemented by staff to help alleviate these. We found that proper steps were not taken to ensure that this persons assessments, care planning and reviews were accurate and that they were protected against the risks of receiving care or treatment by having effective person centred care; did not have adequately detailed care plans in place which should have given staff step by step instructions about how best to support then; did not adapt amend or change the care plans when it was evaluated that staff interventions continued to be unsuccessful.

We found there was a lack of person centred care for those people at the home who had or were at risk of skin pressure damage. We looked at the assessments and care plan records of people at the home who were at risk and found that consistent and competent care had not been given which had resulted in people developing pressure damage. For example, one person who was also at high risk became unwell and their care plan described, "Unfortunately due to ill health at present he is declining the support. Staff continue to monitor skin integrity due to [the person] spending a lot of time sitting in his chair."

Inadequate

Is the service responsive?

However there was no mention of pressure relieving equipment which should have been used to prevent this person from developing a pressure ulcer whilst sitting in a chair. Another person who had been previously assessed by nurses as being at 'high risk' had their pressure relieving equipment removed. This resulted in them developing pressure damage. Their records stated "[Name] airflow mattress has been removed. To replace tomorrow as [name] does not move position when in bed.' There was no explanation as to why their airflow mattress had been removed causing pressure damage. The acting manager told us that the airflow mattress had been removed despite being at 'High risk' and needing to have a specialised bed in place. She told us that the airflow mattress was put back in place when it was found that they had suffered pressure damage. The acting manager told us that the pressure relieving mattress should not have been removed as this had caused this person to sustain pressure damage.

This is a breach of Regulation 9 (Care and welfare) of the Health and Social Care 2008 (Regulated Activities) Regulations 2010.

We found that people who needed support with their nutritional needs were at risk from poor care. However we saw that the care plan documents were not accurate, complete or regularly updated. For example one person had records which nurses had noted that they were at a significant risk of choking whilst eating. However this care plan did not note, consider or instruct staff how to maintain this person's diet and ensured the risks of them choking on food and drink were minimised to monitor this person's diet in relation to other medical conditions. A specific instruction could not be found in the care plan and there was no reference to their use in determining the safety or effectiveness of nutritional or nursing care strategies.

This is a breach of Regulation 14 (Meeting nutritional needs) of the Health and Social Care 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The home was not well run, operational procedures were disorganised and oversight by the provider was ineffective.

We found that the registered manager was no longer in post at the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We looked at CQC records which showed that the previous manager remained registered at the home even though she was no longer employed by the provider. We found the acting home manager and deputy manager had both worked at the home for approximately five months prior to our inspection. However on 4 March 2015, CQC had not received any applications for the registration of a new manager.

This is a breach of Regulation 5 (Registered Manager condition), of the Health and Social Care Act 2008 (Registration) Regulations 2009.

We found that the provider failed to make improvements to the quality and safety of services for people at the home. The provider did not take action following a CQC inspection of 27 and 28 October and 5 November 2014 where the home was found to be in breach of five regulations and people using the service were found to be at risk despite Warning Notices being issued. The provider did not act in a timely fashion to achieve compliance, meet service users' needs and adequately protect them from receiving poor care. Although the provider had taken steps to appoint an acting manager and deputy manager, approximately five months before this inspection, their impact on the service remained inadequate and we found the provider remained in breach of regulations which warranted further enforcement action to be considered.

We found that in a significant number of areas of the home appropriate standards of cleanliness

and hygiene in relation to the premises were not maintained. This included service users' beds, bedding, soft furnishings, chairs / seating and skin pressure relieving equipment. This exposed service users, persons employed and others who may be at risk to a health care associated infection arising from the regulated activities, to the risk of infection. The acting manager told us that she and the area manager carried out audits and checks to ensure standards of cleanliness and hygiene and a safe environment were maintained. The acting manager agreed that despite this monitoring that the service presented an on-going breach of regulation 12, cleanliness and infection control. We found that the systems to regularly assess and monitor the quality of the services and protect service users and other persons from the risk of harm were ineffective.

We looked at how the provider assessed and monitored the quality of the home to make sure it was safe, effective and meeting the Statement of Purpose. We looked at the system used by the acting manager and senior staff to investigate and respond to the number and circumstances that service users living at the home had sustained incidents and found this was ineffective. The acting manager and peripatetic area manager were unable to demonstrate that the circumstances of incidents had been analysed and where necessary changes had been made to reduce the likelihood of reoccurrence in order to improve the service and protect people from potential harm. We found that the provider failed to have effective systems in place to regularly assess and monitor the quality of the services and protect service users and other persons from the risk of harm.

We asked the acting manager for evidence around how the service was monitored or overseen by the provider including any visits by senior managers that had been completed in the last six months. We saw a copy of the document 'Regional Manager Monthly Review-Full' but the most recent was dated 5/13/23 January 2015. The acting manager was unable to produce this information and confirmed that they could not find any such documents and was not aware that any had been produced. We found no evidence that the provider had sought to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of monitoring and assessment systems to oversee the service at Redworth.

This is a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found evidence of repeated on going accidents / incidents which put people at the home at

continued risk or had the potential to result in harm. The acting manager was unable to

demonstrate that the analysis of incidents had taken place and, changes needed or considered in

relation to their treatment and care provided, had been put in place.

For example during the inspection we found that some people who were at risk of pressure damage had had their pressure relieving mattresses removed and had subsequently developed wounds to their skin. There was no evidence that these incidents had been investigated to determine why mattress had been removed, why the settings were adjusted or any evidence that measures had been put in place to prevent a re-occurrence. We found that no central processes had been in place to identify these risks or ensure appropriate safeguarding notifications were made or why there had been a failure to make statutory notifications to the Commission. We found that the provider failed to have effective systems in place to regularly assess and monitor the quality of the services and protect service users and other persons from the risk of harm.

This is a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and, Regulation 18 Notifications of other incidents), of the Health and Social Care Act 2008 Registration Regulations 2009.

The provider failed to ensure that suitable arrangements to protect the health, welfare and safety of service users in circumstances where responsibility for the care and treatment of service users was shared with others. For example, we looked at the 'Evaluation' records in one person's care plan called 'Aggression & Anxiety' which stated that they had been displaying increased behaviours which challenged staff. Staff had promoted the increased use of sedative medication and sought this to be prescribed from the GP. However a visit from a healthcare professional determined that this was not best practice and non- pharmacological approaches should be used rather than medication. They reported that the sedative medication had yet to be increased and that if staff followed the care plan then the increase should not be needed. A written entry from the healthcare professional stated, "the increase to medication seemed to be more for the benefit of the staff rather than for (the service user.)" There was no evidence that alternative strategies had been adopted in the first instance prior to staff contacting the GP to increase this person's sedative medication.

This is a breach of Regulation 24 (Cooperating with other providers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.