Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Canterbury House

Canterbury House
77 Dyserth Road
Rhyl
LL18 4DT

Mae'r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date of Publication

28 May 2018

Description of the service

Canterbury House is registered with Care Inspectorate Wales (CIW) to provide nursing care and accommodation for 51 people over the age of 55 years.

Akari Care Cymru Limited is the registered provider.

There has been no registered manager in post since 16 December 2013. The person who was appointed to the position, in March 2016 is no longer working at the service.

A manager from one of the provider's sister homes was on duty, supporting the service, on the day of the inspection.

Summary of our findings

1. Overall assessment

The inspection was prompted by a number of concerns which suggested the service was not operating effectively. The inspection was carried out to determine the effectiveness of the management systems in ensuring the health, safety and welfare of residents was protected. The visit identified breaches of the regulations resulting in poor outcomes and unacceptable risk of harm to people. A meeting was held with the provider, following the inspection, to discuss our findings and establish what actions had been taken in order to protect the health and welfare of people living in the service.

2. Improvements

We did not focus on this area at the inspection.

3. Requirements and recommendations

There were no requirements made at the previous inspection on 11 July 2017.

Section five of this report sets out our recommendations to improve the service and areas where the registered persons are not meeting legal requirements. These include

Failure of the registered provider to fulfil its legal responsibilities and safeguard the health, welfare and safety of people living in the service. Details can be found in the non compliance notices at the end of this report.

- More activities are needed.
- Ensure levels of staff and their deployment are kept under review.
- Chemicals and cleansing agents must be stored safely.
- Quality assurance systems should be strengthened.
- Forward a copy of the completed report following the provider's assessment of the service.

1. Well-being

Summary
The quality of life for people living in the home does not meet expected minimum standards. People are not protected by the homes policies and procedures and people are not involved in activities which would occupy or stimulate them.

Our findings
Risks are not anticipated and physical care needs are not met consistently and safely. Since January 2018, 11 incidents had been referred to the local authority safeguarding department. Not all of the referrals were appropriate some were practice issues which should have been dealt with by the person in charge of the service and others showed a failure of the providers own processes to reduce the risk of similar incidents occurring. Full details can be found in the non compliance notice. People are not protected from abuse, harm or neglect.

People spend a lot of time doing nothing. There is an activity worker but on the day we visited we did not observe activities taking place. Residents were observed seated in the communal areas with little or no activity taking place. Televisions or radios were playing but people were disinterested. There was no evidence of an activity programme or of opportunities for people to interact socially as a group. We did see different members of staff chatting with people on a one to one basis but, overall the time spent with people was limited as staff were needed to provide care and support. People do not do things that matter to them.

2. Care and Support

Summary

The measures put in place for supervision of people in communal areas is not adequate and the systems for observation and supervision of staff practice, on a daily basis, are not effective. Information relating to individuals needs is not always shared effectively and the care records are not organised in a way that enables information to be found quickly. Full details have been included as evidence in the non compliance issued.

Our findings

People do not always receive the standard of care or support they need as the number of staff on duty is not always adequate. Staff comments and the remarks made in the two concerns suggest levels were not adequate to meet resident needs. One comment made was "*only two nurses on duty to cover the three floors, for day and night shifts. This makes for a pressured workload for the nurse, running between two floors, administering medication, dealing with any emergencies, and overall care needs*" and ' *only three staff to support sixteen patients, one of these needed one to one care, which meant two staff for fifteen patients*'. Staff spoken with told us there was little time to complete their tasks during their shift; one person told us they remained after their shift finished to complete paperwork. One nurse was distressed as they felt one of their tasks was to supervise/guide staff but as they had to provide nurse cover for two floors there was little time to do this effectively as they had their own duties to complete and another person told us they only had time to provide basic care, there was little opportunity to provide 'quality' time for people. We found staff were not always visible in communal areas and we believed that the way in which staffing was organised did not always ensure that the welfare or dignity of people was respected. Full details can be found in the non compliance notice. People do not receive the right care, at the right time in the way they want it.

There are six nurses employed in the service and agency nurses are used to cover vacant shifts and although efforts are made to use the same staff to ensure consistency this is not always possible. Staff had commented that there were delays in the provision of care especially with the administration of medication, handovers did not provide detailed information about residents and their changing needs and the care records did not always contain full details. These comments were supported when viewing the care file which was unclear, disorganised and difficult to follow in addition, information received at a recent safeguarding meeting had confirmed details of needs were not shared at handover. This is poor practice especially when there is a high use of agency staff as they are reliant on good records to ensure they can meet resident's needs safely. Individual needs and preferences are not always anticipated.

3. Environment

Summary
Generally, the home is clean, comfortable and attention is given to maintenance. The safe storage of chemicals must be more rigorous.

Our findings
People are cared for in warm and well maintained surroundings. Corridors were spacious, bright and free from clutter enabling people to move around freely and safely. Communal areas were well maintained and decorated to a good standard. There were a number of areas that could be used by people living in the service and their visitors or, they could meet with them in their own room. Bedrooms were personalised to varying degrees and based on people's individual preferences.

People cannot be confident that unnecessary risks have been identified and, as far as possible eliminated. In general bedroom doors were left open, as residents are able to move freely around the service this means there are occasions where residents may enter other peoples bedrooms, we have received two notifications advising us of incidents occurring leading to resident altercations and damage to personal possessions. This is not acceptable as it does not respect individuals safety, personal space or property and measures must be developed to manage these circumstances more effectively.

In January 2018 a resident was able to enter a room and consume a cleansing agent, we found records which showed two similar incidents had occurred the following month. Fortunately each person suffered no ill effects however, systems must be in place to ensure all chemicals are stored securely to minimise further risk to peoples' safety.

People do not live in accommodation which fully meets needs and enables a sense of well being to be achieved.

4. Leadership and Management

Summary
Currently people living in the home do not receive any benefit from the ethos, leadership and management approach at the home. There have been significant changes to the management structure and operation of the service over the last four months. There has been an increase in incidents and concerns occurring at the service. There has been a lack of direction and organisation and a blurring of roles and responsibilities. Full details have been included as evidence in the non compliance issued.

Our findings
The systems in place to monitor and evaluate the service are not effective. Records viewed demonstrated incidents had been documented but there was no evidence to show they had been evaluated or of measures taken to minimise further occurrences. One person referred to 'sloppy' practice as information was not filed, offices were disorganised and information was mislaid. We found care records were disorganised and difficult to follow, some information was recorded on templates introduced by the previous provider. Training and supervision records were not fully complete. Staffing levels had not been effectively monitored and the rotas and allocation sheets did not always correspond with each other. We did not find any records of reports written by the regional manager to discharge their responsibilities in overseeing the service and there had not been effective support provided to the service until March 2018. People are not aware of the lines of accountability and there is a lack of oversight by the registered provider.

People are not kept informed of developments or have the opportunity to offer views. Staff spoken with felt there was a lack of support and guidance provided for them, did not feel valued and said communication between management and staff was poor. One person said as agency staff were used there was a lack of continuity in practice and they did not know if efforts were being made to recruit staff as" *nobody shares information with us".* Other comments included *"there are no meetings to discuss issues", "handovers are poor"* and '*we are not listened to'*. One relative said a relative meeting had been arranged but was cancelled at the last minute. They spoke highly of the staff group but said there were not enough of them and there were occasions they could see they struggled and were "*demoralised*" they said over the last few months, standards had dropped. These comments suggest people do not have opportunities to contribute to the development or improvement of the service.

A 'supporting' manager had been working in the home a few days a week, for the three/four weeks before the inspection to assess areas of practice. Measures had been taken to address failures and improve the operation of the service. These included a residents meeting to provide people with the opportunity to raise concerns, a staff meeting to explain their role and listen to views, review of staff rotas, filing and organising records and carrying out a full audit of medication storage and administration. In addition, the provider's quality assurance team had attended the service, the week before the inspection and identified areas for improvement. A copy of this report should be forwarded to CIW.

It is positive to note that action is now being taken but, it is of concern that the issues had not been identified sooner, this failure suggests the providers own quality assurance processes are not sufficiently robust to protect people using the service from harm.

People are not currently experiencing effective support from a service committed to quality assurance and constant improvement.

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

None

5.2 Recommendations for improvement

- More activities should be available to avoid people becoming bored, lonely and isolated from each other. In the absence of the activity worker, opportunities should be available for staff to facilitate engagement with and between people who live in the home and be encouraged to spend quality time with them.
- A review of staffing levels and the deployment of staff should be carried out to determine the best way to organise staff to safeguard and promote peoples health and welfare.
- Systems should be in place to monitor and audit practices. These audits must be evaluated and actions taken, as required, to ensure the homes effective operation.
- Chemicals and cleansing agents must be stored safely.
- A copy of the quality assurance report should be provided for information. This should also include details as to why actions had not been taken sooner, the measures taken to reduce the risk of future occurrences and the arrangements for communication for example informing CIW appropriately of significant events and changes regarding the service.

6. How we undertook this inspection

We, Care Inspectorate Wales (CIW) carried out an unannounced inspection on the 26 March 2018 between the hours of 8.40 and 14.20.

This was an unannounced, focussed inspection to determine if the service was operating effectively and managing the needs of residents living in the service.

There were 41 people resident at the service.

Before the report was completed two concerns were raised directly with CIW around poor management and leadership of the service and inadequate staffing levels, comments have been included in the report.

We based our findings on

- A review of information held by CIW about the service; including the last report of the inspection carried out on 11 July 2017.
- Notifiable incidents, safeguarding referrals and minutes.
- Conversations with four people living in the service, nine staff, two visitor's and the 'supporting' manager.
- Observing life in the service. The Short Observational Framework for Inspection (SOFI2) tool was used to formalise observations. With this tool we can record life from the perspective of the person using the service; how they spend their time, activities, interactions with others and the type of support received.
- Viewing communal areas and bedrooms.
- Reading two care plans, chosen at random.
  Viewing
- Staff rotas (for the weeks beginning 3 December 2017 – 4 February 2018).
- Staff allocation sheets (night and day) for December 2017 – January 2018.
- Staff meeting minutes from 23 February 2018.
- Training programme, supervision matrix and absence analysis.
- Residents meeting minutes from 22 March 2018; six residents attended.

Feedback was given to the interim manager at the end of the day of the inspection. Telephone feedback was given to the CEO of the company on the 28 March 2018.

CIW held a meeting with the Head of Business Improvements for Akari Care on 4 April 2018 we were provided with verbal assurances of actions taken to improve the service. The provider has also placed a voluntary embargo on future admissions until the service is more stable.

Further information about what we do can be found on our website:
www.careinspectorate.wales

About the service

Type of care provided	**Adult Care Home - Older**
Registered Person	**Akari Care Cymru Limited**
Registered Manager(s)	**Vacant post**
Registered maximum number of places	**51**
Date of previous Care Inspectorate Wales inspection	**11/07/2017**
Dates of this Inspection visit(s)	**26/03/2018**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	**No**
Additional Information: **The registered provider should review the document 'More than just words' to assist them in developing an active offer of the Welsh language.**	

Care Inspectorate Wales

Care Standards Act 2000

Non Compliance Notice

Adult Care Home - Older

This notice sets out where your service is not compliant with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

The issuing of this notice is a serious matter. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with its enforcement policy.

Further advice and information is available on CSSIW's website
www.careinspectorate.wales

Canterbury House

Canterbury House
77 Dyserth Road
Rhyl
LL18 4DT

Date of publication: **28 May 2018**

Leadership and Management	Our Ref: NONCO-00005781-LLVV
Non-compliance identified at this inspection	
Timescale for completion	**31/05/18**
Description of non-compliance/Action to be taken	**Regulation number**
The registered provider has not taken effective action to oversee the safe operation of the service. Despite auditing processes being in place to monitor the service there are serious shortfalls in the systems.	10 (1)

Evidence

The service is not compliant with Regulation 10. (1)

The registered provider and the registered manager shall, having regard to the size of the care home, the statement of purpose, and the number and needs of the service users, carry on or manage the care home (as the case may be) with sufficient care, competence and skill.

This is because the provider has not complied with all required regulations, created a positive ethos and culture, or monitored and evaluated outcomes for people.

The evidence for this was

A complaint was forwarded for investigation to the R.I in January 2018 and until we contacted the provider no response was received. A response was finally received in March 2018.

The manager had resigned and CIW were not informed of their leaving or of the managerial arrangements put in place until we approached the provider and asked for the information.

The regional manager left the service in January 2018 and the day to day operation was carried out by a deputy who has since left the service; we had not been made aware of these changes.

There was no record of reports by the regional manager about the conduct of the service.
The company had nominated an person to oversee the service, the Responsible Individual (RI), but this person had left the service and we had not received formal notification of this or of the details of the person appointed to take their place.

The training programme listed staff and the training they had received but there were a number of empty columns however we did find other paper records of training in the filing cabinet; from the records viewed it was difficult to establish if staff were or were not trained.

Accidents had been documented but not analysed.

The audits viewed were not up to date.

- There was a medication policy developed by the previous provider but this had not been reviewed and there was no medication audit evident.
- The only health and safety audit we could find was dated October 2016
- Product guidance for control of substances had been printed out but we could find no risk assessments.
- We could only find an internal quality assurance document from January 2017
- There was a file of “external professional’s reports” but this was indexed incorrectly and the documents in place were not all up to date.
- We did find a copy of the five year electrical check but noted this was due for renewal this year.
- An infection control audit had been completed in January 2017 but others could not be located.
- There was a full audit of the catering department completed in September and October 2017 but no additional audits had been saved.
- Audits completed by the laundry person had been completed in January and February 2018 but a full audit by the manager was not evident.

Staff rotas were unclear and did not correspond with the allocation sheets.

Care plans were disorganised and were difficult to follow, some of the information in the files was recorded on the previous provider templates.

Referrals had been made to safeguarding but there was no detail provided of any actions taken to deal with the issues at the time of occurrence to protect resident’s health and welfare or improve staff practice. A number of the referrals were inappropriate which suggests the staff member referring lacked understanding of the process and no records to show any support or guidance offered by the registered provider.

In October 2017 the outcome of a safeguarding meeting was that staff would receive additional training in relation to tissue viability and completion of documentation.

In December 2017 a separate safeguarding meeting identified the same outcomes for the provider. The training programme we were given showed only nine people had received tissue viability training and this was on the 6 October 2017; we did find a file containing other training records from 2016 and 2017 but it was not fully complete therefore it was difficult to establish if all staff had received the training.

There was an ‘analysis’ log which included details of a variety of incidents and occurrences relating to equipment and incidents affecting both residents and staff. Some information was inappropriately recorded and would have been better placed in an individual care plan or the staff member’s file to ensure confidentiality.

There were two incidents which had happened in January 2018, regarding the conduct of staff we had not been notified of these incidents.

In January we had received notification of an incident where a resident had eaten cleansing products. The analysis identified a second similar incident in January and a third incident in February.

On 22 March we had been notified of an incident occurring resulting in an injury to the resident.

Statements had been provided by staff but these described staff whereabouts, there was nothing to show any investigation had been carried out to discover how the injury occurred and there was nothing to indicate what additional action should be taken to monitor this person and reduce further incidents occurring.

These incidents suggest the measures in place to monitor and evaluate outcomes for people or to provide additional support and guidance for staff to minimise the risk of incidents re occurring are not rigorous.

The evidence indicates that the lack of a registered manager to provide leadership and direction for staff and the lack of support by the registered provider has had a negative impact on the operation of the service and the delivery of care for people living in the home. CIW cannot be confident that the management arrangements at the home are appropriate.

The impact on people is that they may receive poor quality care and live in a service where risks are not appropriately managed.

Leadership and Management	Our Ref: NONCO-00005782-TBYK
Non-compliance identified at this inspection	
Timescale for completion	**31/05/18**
Description of non-compliance/Action to be taken	**Regulation number**
The individual and collective needs of people living in the service are not managed effectively or efficiently and risks have not been anticipated.	12 (1) (a)

Evidence

The service is not compliant with Regulation 12. (1)The registered person shall ensure that the care home is conducted so as

(a) to promote and make proper provision for the health and welfare of service users

This is because staffing levels or deployment of staff has not ensured the health, safety and welfare of residents is managed effectively. At the last inspection we recommended “a further review of staffing levels and the deployment of staff should be carried out”. Although a dependency tool, to determine staffing levels is used the incidents occurring indicate that further review is required.

The evidence is that

People are not always cared for by familiar staff as there is a regular use of agency staff. There has been a high turnover of nursing staff and the service has relied on agencies to provide cover for shifts which has not been an ideal situation. The information for agency staff in relation to care for individuals is not sufficiently detailed to enable care to be delivered in line with the needs and wishes of people and there is an increased dependency on care staff to provide relevant information when leading a shift.

The rotas viewed showed the number of nurses on duty each day, varied between one and three and the number of care staff between seven and twelve (on one occasion) however, the allocation sheets showed where agency nurses had been used. The allocation sheets did not specify points of the day only the day and when we compared the rota with the sheet we found there were occasions when one of the nurses left at 2 pm which supported the allegation of only two nurses on duty. With only two nurses on duty, due to the size, layout of the building and the complexity of needs it would be difficult, for the nurses to ensure appropriate care and support of people, completion of care records and supervision and guidance for care staff.

The service provides care for people living with dementia but the majority of nurses working in the service are predominantly general trained. There is no clinical lead nurse with dedicated responsibility for overseeing clinical practice or to lead and guide staff. The rotas showed that there is not a separate nurse on duty on each floor, every day and usually the nurse does not

have the time to work alongside staff to observe practice as they are completing their own nursing duties.

It would benefit people living in the service if there was a designated nurse who could observe and monitor practices, ensure required information is documented and kept up to date and provide people living in the service or their relatives with the opportunity to raise any concerns.

There are three floors supporting residents with a variety of physical and mental health needs. Each floor has people who require two people to attend their needs, have various behavioural issues or are active. Staff told us this creates difficulties as if they are attending to resident's personal care the level of supervision of the remaining residents is reduced which increases the risk of incidents happening.

On the top floor there were nine people. Two care staff were allocated to this floor and the nurse was dividing her time between this and another floor, if staff were attending to the needs of people in their room there was no visible staff support of residents in communal areas. Four people were seated in one of the lounges, three were asleep the television was on but the person showed little interest. A member of care staff was seated in the lounge completing care charts but overall there was little interaction taking place. One person was attending an appointment and four people remained in their bedrooms located at the opposite end of the floor. Due to the layout of the floor and the location of residents it would not be possible to ensure all resident's needs could be safely met.

We had been advised of three occasions where people had entered other residents rooms; a resident had eaten soap, broken a picture frame and sat on the legs of a person in bed. We read an incident form from 23 March which stated a resident had entered another persons room and tried to pull them from their bed, two further incidents where people had eaten substances and we observed one person to enter the bedroom of another and lie on their bed.

One care plan identified a resident at high risk of falling and before admission to the service had been receiving 1:1 support, in the actions a record had been made for staff to "try and do this if levels allow." We found entries in this persons care plan which showed the person fell on a regular basis and on 3 December 2017 they had fallen on seven occasions.

The evidence indicates that there is a lack of consistency in care, lack of guidance and supervision of staff and their practice. Staffing of the home is not organised so as to deliver care that promotes and eliminates unnecessary risks to peoples' welfare, areas requiring improvement have not been identified through the registered provider's own quality assurance processes and there is a lack of guidance and direction for staff.

The impact on people using the service is an increased risk to their health and safety and a failure to protect them from harm or neglect.