Gateway Residential Home

The Gateway Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 23 November 2016 and was unannounced.

The Gateway is a large detached property, providing residential care for up to 16 older people who may be living with dementia. The service is located within the town of Dover. The bedrooms are situated over the ground and first floors and are a mixture of single and shared rooms. The communal accommodation is situated on the ground floor and comprises of a large lounge with dining area and a small quiet area. There were 15 people living at the service at the time of the inspection.

There was a registered manager in post. 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.

The provider had notified the Care Quality Commission (CQC) that they were no longer trading as a partnership; however, they had failed to process the change of the partnership to a single provider to ensure the service was registered correctly. This meant that the service was not legally registered. The provider did not have oversight or scrutiny of the service.

The registered manager had an understanding of the day to day running of the service and knew people well, however, they lacked knowledge of the regulations to ensure the service was compliant. Policies and procedures were undated and not reviewed in line with current legislation. There were systems in place to audit and check the service but these had not been effective as they had not identified the shortfalls found at this inspection.

Although people told us they felt safe living at the service, people were not fully protected from harm. Risks were not always managed safely. Risk assessments to show staff how to support people safely were not detailed, there was limited information on how to reduce the risks. Some risks had not been identified, there was no guidance for staff to use some equipment to support people with their mobility.

Accidents and incidents had been recorded but lacked detail of the incidents. They had not been analysed to identify what action could be taken to reduce the risk of further incidents.

There were environmental risk assessments which had identified areas of improvement, such as windows requiring repair and the garden not safe to use. However there were no maintenance plans in place to complete the work required.

Checks had been carried out on the premises such as gas safety and the lift. There was a system in place to regulate the water temperature, but there were no records to show that the temperature of the water had been checked in people's bedrooms to reduce the risks of scalding.

The fire system had been checked on a regular basis and fire drills had been completed. However, not all staff attending these drills had been recorded to ensure that they all had a full understanding of what action to take in the event of a fire.

People told us they received their medicines at the times they needed them, however the systems in place to order and record medicines were not safe. The medicine audits carried out by the registered manager had not identified these shortfalls.

Staff were not always recruited safely. References had been obtained to check prospective staff's conduct in previous employment, but these had not been verified.

Staff told us that they received appropriate training for their roles. However, we were unable to confirm that staff training was up to date as training records did not indicate when the training had taken place and when updates were required. Staff received supervisions and appraisals but these had not always identified the development needs of staff.

There were sufficient staff on duty to meet the needs of the people living at the service and the staff rota was consistently covered in times of staff absence.

Although staff sought consent from people when providing care, the assessments of people's capacity to make decisions as required by the Mental Capacity Act (MCA) were not detailed or decision specific.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Staff did not have a clear understanding regarding DoLS as there were people living in the service whose capacity had not been assessed, who needed constant supervision and were unable to leave the service. No DoLs applications had been made in these cases.

Staff were responsive to people's needs but care plans were not always detailed or person centred. Care plans did not contain details of people's choices and preferences. Care plans had been reviewed but changes to people's care needs had not been recorded.

There were limited activities available for people. People were supported to express their views and raise concerns or complaints which were acted on and resolved to their satisfaction. People's privacy and dignity was not always maintained, staff spoke to people loudly while in the lounge which was not necessary.

Staff understood how to report safeguarding concerns but the service's policy required updating to ensure that staff had the current guidance to refer to. Staff were aware of the whistle blowing policy and were confident the registered manager would take the required action. The registered manager had not consistently notified the Care Quality Commission of events within the service as required.

People were supported to eat and drink enough to maintain good health. Staff responded quickly to people becoming unwell. People were supported to access health care appointments and staff monitored their weight and general health, involving relevant health professionals as required. People were supported to maintain good health and their independence where possible.

Staff knew people well and knew their likes and dislikes. People and relatives told us the staff were kind and caring.

There were positive and caring relationships between people and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all potential risks had been identified and those that had did not have measures in place to reduce the risk to keep people safe.

Accidents and incidents were not always recorded accurately.

Medicines were not managed safely. Guidance was required for giving people 'as and when' medicines. The recording of medicines in stock did not meet current guidelines.

Staff were not recruited safely.

The premises was in need of repair and refurbishment but there were no plans in place to address these issues. The garden area was not safe for people to use.

There was enough staff on duty to meet people's needs

Staffs knew how to report any suspicion of abuse and were aware of the whistle blowing policy.

Is the service effective?

Requires Improvement

The service was not consistently effective

The principles of the Mental Capacity Act (2005) were not followed. There were no capacity assessments or Deprivation of Liberty Safeguards referrals.

The induction for new staff was not in line with current guidance. Staff had received training but there were no records to confirm that the training had been updated in line with best practice.

People were supported by staff that knew them well Staff offered people choices in ways they understood.

People's nutritional and their health care needs were being met. Health care professionals were consulted when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was compromised by staff in the communal areas as staff talked loudly to people.

People who lived in shared rooms had no means of maintaining their privacy and dignity.

People's rooms were personalised to their tastes, people were encouraged to maintain their independence

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff knew people well, but care plans were not always person centred.

Care plans were reviewed, but were not always updated to reflect people's changing needs. Staff were not using the care plans as guidance.

There were limited activities available for people.

Visitors were always made to feel welcome.

People knew how to complain and were confident the registered manager would listen and take appropriate action

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have oversight or scrutiny of the service to monitor the quality of care being provided.

The provider was not legally registered with the Care Quality Commission.

The registered manager had not received guidance or supervision from the provider. Some audits had been completed but these were not effective to continuously improve the service. The shortfalls in this inspection had not been identified.

The registered manager did not have an understanding of the current guidance regarding medicines management, deprivation of liberty safeguards, mental capacity act and risk assessment.

Accidents and incidents were not analysed to identify patterns or trends to reduce risk of further events.

The registered manager had not consistently notified the Care Quality Commission of events within the service as required.

Staff told us that they felt supported by the registered manager and understood their roles and responsibilities.

The Gateway Residential 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.

The inspection took place on 23 November 2016 and was unannounced. The inspection was carried out by two inspectors.

The registered manager had completed 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. We looked at previous inspection reports and notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury.

We looked at all areas of the service and talked to four people who live at the service. Conversations took place with people in the communal lounge and their bedrooms. We observed the lunch time meal using a Short Observational Framework for Inspection (SOFI) and observed how staff spoke and interacted with people. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three relatives, three staff, the cook and the registered manager. We looked at a range of records including three care plans, three staff recruitment files, induction records, training and supervision, staff rotas and quality assurance surveys and audits.

The previous inspection was carried out in September 2014, there were no concerns noted.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. They said: "I feel safe, they come when I call". One relative told us, "My (relative) is very happy here and we are all welcome".

Although people told us they felt safe, we found examples of unsafe practices in the recruitment of staff, medicines management, risk management and the maintenance of the building and garden, all of which placed people at risk.

We were unable to check if people were receiving their medicines as prescribed because the recording of the medicines received and stored within the service had been completed incorrectly. The amount of tablets left in the boxes did not match up with the records that had been completed when the medicines had been received. One person had received 28 tablets on 31/10/16 and there had been 11 tablets carried over from the previous month. There should have been 16 tablets left in the box but there were only 14. When discussed with the registered manager, the medicines that were carried over had been recorded on the sheet the week previous to the new medicines being started. Therefore the amount carried over was incorrect on the 31/10/16. We found this was the same for all medicines that had been counted. Some medicines had not been recorded as being received so there was no accurate record of what medicines were on the premises.

Some medicines had specific procedures which should be followed with regards to their storage, recording and administration. These medicines were not being recorded in line with current guidelines and best practice. The medicines needed to be recorded in a separate book and required two staff to administer and sign the book. The service did not have a book to record the medicines and did not follow guidelines with the administration. When the amounts of medicines in stock were checked there was a discrepancy. The medicine administration record (MAR) showed there were 85 in stock on 31/10/16 when counted at the inspection there were 89. The MAR sheet showed that two tablets had been given each day, therefore we could not be assured that people had received their medicines in line with their prescribed instructions.

The room temperature and fridge temperature had been recorded now and again and had been within acceptable limits for the medicines to be stored at the right temperatures so they remained effective. The temperatures had not been recorded daily to guarantee that the medicines were always stored correctly.

The provider had not ensured that medicines were managed safely in line with current legislation and guidance. This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

We observed a medicine round; medicines were given by two staff, and were administered safely. Some medicines were prescribed at specific times to remain effective; people told us they received their medicines when they needed them.

Risks relating to people's care and support had not always been adequately assessed or managed. Staff

were not given detailed guidance in how to mitigate risks when providing care and support. There were moving and handling assessments in place but the information within these were limited to show how people were being moved safely. One person required a hoist with large sling and a handling belt, there was no explanation about when to use the belt or how to use the sling. The assessment stated two staff were needed but there was no information or guidance on how they should support the person safely.

Another person had poor eyesight and was able to mobilise independently, there was no risk assessment about how to promote their safety around the service, such as ensuring the floor areas were free from hazards. Another person had fallen when they stood up or got out of bed, there was no risk assessment or guidance for staff about how to monitor or reduce the risk. One person was observed being supported by staff to use a transfer aid but this information was not recorded in the care plan to ensure staff had the guidance to move this person safely.

People who had been identified of being at risk of developing pressure areas had special equipment including mattresses and cushions, to help prevent skin damage. There was no system in place to check that the equipment was working correctly and was set at the correct pressure for each person. When equipment is not set at the correct pressure there is a risk that damage may be caused to the skin. It was identified that one person was unable to move themselves in bed, but there was no guidance about how or when to change their position to ensure their skin remained as healthy as possible. .

Staff provided support to people living with diabetes; one care plan gave information about acceptable blood sugar levels. Other plans did not give details of levels that were normal for that person. The care plans did not give guidance on what to look for when the person had high or low blood sugar. One person had a 'Hypo' box in their room if their blood sugar level dropped; however there was no guidance on how or when to use the box. There was a risk that staff would not use the box correctly.

Equipment had been checked to ensure it was safe to use. Checks on the fire system had been made on a regular basis and fire drills had been completed, but staff attending these drills had not been recorded to ensure that all staff were included, to ensure they had a clear understanding of what action to take in the event of a fire.

There were plans in place in case of emergencies, such as fire, these were specific to individuals, with details to maintain their safety and how to evacuate them if required.

A dog that had been owned by a person using the service was adopted by a member of staff. The dog came into the service each day; however, the registered manager had not assessed the risks that the dog posed to people who were ambulant.

Although we observed people receiving safe care, there was a potential risk that without guidance staff who did not know people well, would not be able to give safe care.

The provider had failed to ensure that treatment was provided in a safe way. There was a lack of risk assessments to guide staff in relation to the health, safety and welfare of people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014

A relative commented: "The premises are 'tatty round the edges" and could do with some redecoration and refurbishment. I know that some new carpets have been laid but the carpet in the bottom lounge needed to be replaced". "I have been visiting for years and have never seen any painting going on".

Some areas of the service were in need of refurbishment. The registered manager told us that some carpets had been replaced but the main lounge carpet had not. The registered manager told us that they had purchased new mattresses, people's bedrooms had been painted and some chairs in the lounge had been replaced. There was no maintenance plan and no identified budget to ensure the premises was safely maintained and the necessary improvements made. The outside of the house was in need of repair including the replacement of some windows. People did not have the opportunity of going into the garden as this was not safe at the time of the inspection. The registered manager told us that no funds had been provided to improve the garden. A relative said that in the summer there was not always enough staff to take people into the garden.

There were areas within the service that needed attention, the laundry room was small and meant that clean laundry was kept in the same room as the dirty laundry. The room had plaster missing and the sink and washing machine were damaged and dirty.

Recruitment procedures were not always safe as the registered manager had not ensured that gaps in people's employment history had been accounted for and recorded. In two staff files, the references received were not from the potential staff member's previous employment. Two members of staff had started working at the service prior to their Disclosure and Barring Service (DBS) check having been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The registered manager told us that they had not worked alone until this check was in place but there was no record on the rota to confirm this.

The provider had failed to operate effective recruitment procedures to make sure the relevant checks had been made to ensure staff were suitable to work at the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

New staff had completed an application form, there was proof of the person's identity and health declarations had been completed. Staff had to complete a probation period to ensure they had the right qualities and skills to work at the service.

Some relatives told us that there was enough staff on duty, however one relative commented that sometimes staff were not always in the lounge to respond to people's calls. We observed the lunchtime meal in the lounge. People's dignity was compromised as there was one member of staff to serve the meal to 11 people. People did not receive their meals at the same time and some people had finished eating when others received theirs. The member of staff was polite but the interaction with staff was minimal. Staff did not have time to sit and encourage people to eat their meals or ask if they wanted anything else.

We recommend that the provider look at the deployment of staff in the dining area during meal times.

At other times during the inspection there were sufficient numbers of staff on duty and staff were responding to people in a timely manner. There was a fixed staff rota which did not change each week. The registered manager told us that this worked well as staff always knew in advance when they were working. The staff rota matched the number of staff on duty, and showed that this level was consistent to ensure people's needs were fully met. In addition to the care staff there was a cook and one domestic member of staff. Staff told us that the service was always covered in times of sickness and annual leave. The registered manager also supported the staff when required.

Staff understood what they needed to do if they suspected abuse and had received training on how to keep people safe. They told us they would report any concerns to the registered manager and were confident that

appropriate action would be taken. They were aware of whom to report abuse to outside of the service such as the police or local safeguarding authority. Staff told us they would not hesitate to report any poor practice that they observed to the registered manager and were aware that staff would be protected under the whistle blowing policy.

Requires Improvement

Is the service effective?

Our findings

People told us that their health needs were met. "The staff look after me and contact my (specialist) nurse, if needed". One person said, "The staff know when I am under 'par', we then discuss if I need the doctor or they will suggest the doctor comes".

People told us that the staff knew what they were doing and were well trained. They said staff always asked them for their consent when they were supporting them.

One relative told us the staff were very good and ensured that their relative's health care needs were monitored and met. They said, "We are very happy with everything".

There were mixed views with regard to communication. One relative commented that the staff were not always good at telephoning them to update them with their relatives care. Other relatives told us that the staff were 'excellent' at calling them with any concerns.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions, and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of MCA. There had been no applications for DoLS authorisations by the service at the time of the inspection.

People's mental capacity had not been assessed to consider whether any applications should be made. The registered manager did not have a clear understanding of capacity assessment or DoLS. There were people living at The Gateway who were unable to leave the service and needed constant supervision but DoLS assessments had not been completed and authorisations to ensure the constant supervision was lawful had not been applied for.

There were DoLS checklists in the care plans, however, these had not been completed in line with current guidance. There was no guidance within the care plans, for staff, about people's capacity to make decisions and what to do if they were unable to. Staff were able to explain how they made sure people were supported to make decisions and told us they would not hesitate to report any changes to the registered manager if further support was needed.

Some people had been asked to sign their care plans to confirm that they had been involved. Other care

plans had no evidence to confirm the person or their relatives had been consulted. There was no evidence that best interest meetings had been held for any decisions. A decision about a person having bed rails had been taken by staff, there was no evidence that the person, their relative or another professional had been consulted.

The provider has failed to ensure that staff, were working within the principles of the Mental Capacity Act (2005), and are able to apply those when appropriate, for people they are caring for. This is a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

There was a training programme in place and staff told us they received the training they needed to fulfil their role. Staff were completing long distance learning as part of the training programme as well as face to face training, in subjects such as moving and handling and first aid. Although the training matrix showed that the majority of staff had received basic training, there were no dates to confirm when the training had been provided or training should be refreshed. We asked the registered manager to confirm the training dates after the inspection but the report was still not detailed enough to show the dates the training had taken place.

Some of the training certificates on staff files were out of date, for example, safeguarding and fire training were dated 2009, infection control 2008 and medicines 2008. Another staff file showed that they had completed fire training, safeguarding training and infection control training in 2016. Therefore we could not be assured that the full training programme was up to date.

Staff told us that they had received ongoing training through distance learning but had not completed any practical moving and handling training for a while. The training matrix did not show any dates to confirm this.

There was evidence in the staff files that the registered manager had observed staff providing care, and giving medicines to assess staff competencies. A very brief note was made to confirm this had taken place. The record just noted what the task was and did not have any further information about how the staff member displayed their competencies.

New staff received and induction which was a tick box form to say they had completed certain tasks and shadowed established staff before staring work on their own. The registered manager told us that they were in the process of obtaining information from Skills for Care to introduce the Care Certificate for new staff. The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life.

We observed people receiving safe care from staff who knew them well. There was a potential risk that without accurate records the provider would not know when refresher training was due.

Specialist training such as how to administer insulin had been completed by staff and some staff had also completed dementia training. Fourteen staff out of the twenty staff had completed vocational level 2 or 3 qualifications in social care.

The registered manager was supporting staff with regular supervision and had one to one meetings, however records showed that the content of the supervision was brief and did not cover all aspects of a staff member's role. Appraisals were also very brief and did have details of staff's training and development needs. This was an area for improvement.

People's health care needs were monitored by staff. People and relatives told us that specialist health care professionals were contacted when needed. "They changed my medicines and staff made sure I had them when I needed them". The Parkinson's nurse monitored people within the service who were living with Parkinson's disease. People attended regular appointments with chiropodists, dentists and opticians.

People living with diabetes attended specialist screening programmes and when required health care professionals such as the speech and language team had been contacted to review their care. People had regular health checks from the GP and district nurses to monitor health conditions. Staff contacted emergency services when required.

People told us that their dietary needs were catered for, "I am vegetarian, and the cook always cooks me fish whatever I want". People had a choice of two meals and were asked what they would like to eat every morning.

People could choose to eat their meals in the lounge or in their rooms. At lunch there was an opportunity for people to chat and enjoy each other's company. The meals were well presented and hot, people made comments about how nice the food was and that they enjoyed it. One person said "I enjoyed my meal today, but couldn't eat anymore". Some people required a pureed diet in line with medical advice. The meals were pureed in separate sections and looked appetising. Staff supported people with their eating and drinking when needed.

There was a four weekly menu, and people were encouraged to make suggestions about what they would like to eat. The cook made sure that the meals were low in sugar and suitable for people living with diabetes to eat. The cook was aware of peoples likes and dislikes and these were recorded.

Requires Improvement

Is the service caring?

Our findings

People said, "The staff are kind and respectful, they are good, you only have to ask them anything and they will do it". "The staff are kind and respectful, they always say please and thank you". "I can go to bed and get up when I like, I have breakfast in bed, they (the staff) come up with my tablets and cornflakes". "If I want to go to bed I just ask and the staff take me up". "The staff could not do anything better for me".

Relatives said the staff were kind and caring. One relative said, "My relative is happy here; they like the staff and enjoy living here".

People's privacy and dignity was not always respected. People who wanted to share a room had no means to maintain their privacy. Shared rooms did not have any screen or curtains that could be used for privacy. The registered manager told us that one person went to bathroom to wash and the other washed in the room, this would be at the same time. People only shared rooms when they wanted too and were happy with the arrangement. However, there was no plan for when people were unwell and wanted privacy, changed their minds about sharing or what they wanted to do or for privacy at night.

We recommend that the provider gives thought to how privacy and dignity can be improved within shared rooms.

Staff did not always treat people with respect. People sat in the communal lounge during the day, a relative told us, "The lounge can be loud". We observed staff speaking loudly across the lounge to each other and to people during the inspection, asking people if they needed the bathroom. People who wanted something had to ask in a loud voice as staff were not near them. This was an area for improvement.

Staff understood and respected people's privacy and dignity when working on a one to one basis. One person said: "The staff are all very helpful. They help with my personal care and always treat me with dignity and respect". Another person said, "Privacy and dignity, yes they are excellent at this".

Staff encouraged people and supported them in a dignified way. Staff routinely gave people choices of where they wanted to sit or what they wanted to drink.

People told us that the staff promoted their independence. They said, "The staff are there, but I do as much as I can, but if I ask for help they will do it".

Staff remained close to people but enabled people to do as much as possible, supporting when asked. We observed people using a frame to walk, staff were there to step in and give assistance if needed. Staff gave the person verbal encouragement and prompts to enable them to walk independently.

People were called by their preferred name, people were given the choice of when they wanted to get up and go to bed. People were able to spend their time where they wanted. People were supported to move around the service when they wanted during the day. Some people spent the morning in the lounge and

then went back to their room. Staff knocked on people's doors and waited until they were asked to enter.

People's care plans were stored to maintain people's confidentiality. People's care plans contained information about what and who were important to them and important events in their lives. Staff were able to chat to people about their lives and had built up relationships with them. Relatives told us that they were also made to feel welcome and offered refreshments.

Some people had made advanced decisions about their care. They had 'do not resuscitate' authorisations in their records, this had been discussed with relatives and other health professionals and the person if they were able. However, the care plans did not contain detailed guidance about people's end of life wishes. This was an area for improvement.

When a person wanted to come into the service they had been worried about what would happen to their dog. A member of staff had adopted the dog and brought the dog in each day for the person to see. The person was more settled living at the service knowing their dog was well cared for. People enjoyed having the company of the dog, one person told us "I like to see (the dog) in the morning, it makes me smile".

Requires Improvement

Is the service responsive?

Our findings

People told us that staff responded to their calls promptly. They said, "Staff come quickly when I call my bell even at night time, they are always there within five minutes".

Some people had been involved in the planning of their care, and had signed their care plan to confirm this. There were pre admission assessments in place detailing health care needs, preferences and social needs. There had been no recent admissions to the service. Some of the information from the pre admission assessments seen had been used as part of the care planning process to write the care plan.

Each person had a care plan in place. The plans included a life history that staff were able to use to form relationships with people. There was information about people's health care needs and medicines information. This had been used to identify the support the person may need, such as their mobility needs, skin care and history of falls. Staff recorded in people's care plan what they could do for themselves and what level of support they needed. There were details of people who were important to the person and how they could be contacted.

The care plans did not contain details of people's preferences and choices. There was no information, for example, about when people liked to get up and go to bed. The care plans did not include details of people's personal choices such as the toiletries they liked to use. This was an area for improvement.

There was some detail in the care plans about what people were able to do in regards to their personal care. One person was able to wash their upper body and legs but required help with their back and feet. Staff knew about people's needs and their backgrounds and the care and support they required.

The care plans had been reviewed by staff, but changes in peoples care needs had not been updated. The care plans did not give sufficient guidance for staff to give consistent, safe care.

One person's eating and drinking care plan stated that the person had a daily fluid restriction of 1.5 litres. There was no fluid chart in place to monitor this, the registered manager and a member of staff told us that the person no longer had this restriction. The care plan had been reviewed within the last month, but staff had not recorded the changes to this persons care to inform staff that the restriction was no longer in place. There was no confirmation from the GP that the restriction had been changed.

People and relatives told us that they did not have any complaints. They said they would speak with the registered manager if they did and were confident that they would take action to resolve any issues. There had been three complaints this year, which had been investigated, responded to and resolved. The complaints procedure was on display in the hall way which had information which was no longer current. Also the complaints policy needed to be reviewed and up dated in line with current guidance so that people had a clear understanding of the process to complain. This was an area for improvement.

People told us that they had regular residents meetings where they discussed the food or any other issues.

Records showed that the registered manager had discussed how to complain with them and acted on issues raised. When people requested rolls instead of bread, these were provided and tea cakes were made available at tea time.
People were not receiving support to follow their choice of activities. There was no record to show that people had been consulted about what was important to them and what they liked to do during the day.

There was no formal programme of activities and staff provided activities such as bingo on an ad hoc basis.. One person told us that they liked some activities but they preferred to read and do puzzle books and did not always join in the entertainment. Another person said they had bingo sessions and exercise classes each week. A relative told us that the television was always on but they were not sure if people actually watched it.

We recommend that the provider ask people what activities they would like to take part in and plans a range of activities accordingly.

People told us they were looking forward to going out to dinner next week as a local charity had arranged for a Christmas dinner to be provided. There were five people attending this event.

People were encouraged to have visitors, one visitor told us, "I can come at any time, I am always welcome". One person said, "My (loved one) has their dinner with me often and they are coming to spend Christmas day with me, it means so much".

Inadequate

Is the service well-led?

Our findings

People told us that the registered manager did a good job. One person said, "The manager is a nice person, they get on well with everyone".

The provider had notified the Care Quality Commission (CQC) that they were no longer trading as a partnership; however, they had failed to process the change of the partnership to a single provider to ensure the service was registered correctly. This meant that the service was not legally registered. We told the provider to process the new registration without delay.

The provider did not have overview or scrutiny of the service. The registered manager had not received any support from the provider to run the service. There was no guidance or supervision from the provider to ensure that the quality of care being provided was to the correct standard. Effective systems were not in place to check the service was meeting the regulations.

The registered manager did not have any other managerial support to help with the management of the service. There were no clear lines of responsibility in the service. The staff structure did not include a deputy manager to assist with the running of the service.

A relative told us that when the registered manager was not on duty they did not know who was in charge of the service.

People told us that they knew who the registered manager was and saw them most days. We observed the registered manager speaking to people, there was a warm and friendly relationship.

The registered manager told us they completed annual checks and audits on all aspects of the service. These audits had not identified the shortfalls found at this inspection. The audits were a series of tick boxes, when it was identified that there were issues there was no action plans in place to show how these issues were being addressed and when they had been actioned to continually improve the service.

The registered manager did not have knowledge of current good practice. The systems in place for medicine storage and recording did not meet current guidelines. The requirement for the assessment of consent and identifying Deprivation of Liberty Safeguards had not been completed correctly. The registered manager had not made themselves aware of current guidelines or asked for assistance to ensure that the service was meeting the required standard.

The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely, however these had not been reviewed in line with current legislation. The policies did not have a date when they were implemented and there were no review dates. There were two undated safeguarding policies and the complaints procedure had incorrect information about how to contact outside organisations. The registered manager had identified that the policies and procedures needed to be up dated and told us they had started to do this but it was slow progress due to lack of the support from the

provider.

Staff meetings were held to give staff an opportunity to raise any issues with the service. The minutes did name the staff who attended; there was no agenda and no review of the minutes of the previous meeting. The meetings were brief and focused on individual subjects such as medicines. There was no evidence to show how staff had contributed to the meeting or were able to raise any concerns or issues about the service. Therefore, it was not possible to judge the effectiveness of staff meetings or to know if staff's concerns or requests had been dealt with.

Accurate and complete records in respect of each person were not maintained. Risk relating to people's care and support had not always been adequately assessed. Care plans had been reviewed but not updated to reflect people's changing needs. Records relating to the recruitment of staff and staff training were either not in place or not accurate or up to date.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service, so we can check that appropriate action has been taken. This includes when safeguarding alerts were made to the local authority. The registered manager was aware of the requirement to inform CQC of important events but this had not been consistently adhered to. The CQC had been informed of some events but not all. The current CQC report was displayed in the entrance hall.

The registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. Records were not clear and completed accurately. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives, staff and health care professionals had the opportunity to provide feedback about the service. They had completed quality surveys this year with positive comments about the service. Health care professionals said the staff were always welcoming, knowledgeable and understood people's needs. Staff indicated that they were supported well by the registered manager and had enough training to do their jobs well. Relatives commented that they were satisfied with the service and were mostly kept informed of their relative's needs. The registered manager had not analysed the surveys and given feedback to people to show their comments were used for the continuous improvement of the service. This was an area for improvement.

The registered manager attended local forums to share good practice and network with other providers. Staff told us that they worked well as a team to make sure people had the care they needed. They said the registered manager was approachable and supported them to carry out their roles. Staff also said that the registered manager 'was busy, always busy'.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure staff were working within the principles of the Mental Capacity Act (2005) and are able to apply those when appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that medicines were managed safely in line with current legislation and guidance. The provider has failed to ensure that treatment was provided in a safe way. There was a lack of risk assessments to guide staff in relation to the health, safety and welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to take appropriate action to mitigate risk and improve the quality and safety of services. Records were not clear and completed accurately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider had failed to operate effective recruitment procedures to make sure that relevant checks had been made to ensure staff were suitable to work at the service.