K N & S Ramdany

Holly Grange Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

Holly Grange Residential Home is a small home which usually only accommodates up to 16 people with needs relating to old age. Three further beds are available which would only be used where people specifically wished to share. The service does not provide nursing care.

The service has a registered manager. 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.

People were potentially at risk because staffing levels within the service during the day and at night, were not sufficient to meet people's needs and some staff were working excessive and potentially unsafe hours. Staff rotas were either inaccurate or were not available to establish who was scheduled to be on duty.

Staff were not properly inducted, supported or trained to ensure they had the necessary skills to meet people's needs.

The service did not always provide safe care and treatment. A number of health and safety and fire safety risks had either not been identified, or had been identified but not addressed. There was no evidence that necessary safety checks, such as of bath/shower water temperature, had taken place. Some moving and handling equipment was unsafe and some safety equipment was missing, located inappropriately or not regularly tested. These issues placed people at risk of potential injury.

Care plans and other records sometimes lacked sufficient detail, contained conflicting information or had not been updated effectively to make the current information readily available to staff to meet people's needs. Where risks to people had been identified, this was not always reflected in the care plan with details of the actions staff needed to take to minimise the risk of harm. Inaccurate skin integrity risk assessments placed people at risk of not receiving appropriate care.

There was no evidence of follow up with regard to injuries noted on body charts, in order to identify the cause and any necessary actions to reduce the risk of recurrence.

People were not always kept safe. On one occasion we found the front door open and unsecured, meaning that people could have left the service unobserved or unauthorised people could have gained access to the building.

Some additional fire safety equipment and written guidance regarding evacuation in the event of fire was required and the service had no contingency plan in the event of foreseeable emergencies.

People were placed at potential risk of infection. The service did not have appropriate equipment to sterilise

commode pots.

No Legionella testing of the water supply had been carried out to ensure the water supply was free from this hazard.

Support provided to people with their medicines was not fully compliant with national guidance. This meant people may not receive their medicines in accordance with their wishes or in a consistent way in the absence of clear guidelines.

The registered manager did not have a clear understanding of the legislation around people's rights, freedom and consent. It was not clear whether, or to what degree, people had the capacity to make decisions for themselves, or who had the right to do so lawfully on their behalf. It was not clear whether some people should be safeguarded under the Deprivation of Liberty Safeguards associated with the Mental Capacity Act 2005.

Some equipment had been, or was being used, which could potentially restrict people's liberty. It was not clear whether appropriate consultation had taken place to ensure that consent was obtained or the decision had been made in the person's best interests.

People were not always treated with respect and dignity, their views had not always been sought and their wishes were not always respected. At times staff failed to knock on people's bedroom doors before entering. The language used within records of people's care was not always respectful.

The service was not well led. There was no effective system for the ongoing monitoring and review of the operation of the service. The registered manager had failed to identify or address a range of fire safety, infection control and health and safety-related issues which were identified at this inspection and by the commissioning local authority. He had failed to carry out effective review and monitoring of the quality and content of care records. The staff rotas misrepresented the actual staffing levels.

The registered manager was not fully aware of the relevant legislation in respect of the service. This meant that people's wellbeing, rights or proper communication with others could be compromised.

Overall, we found the management of the service to be largely reactive rather than proactive. This meant that people were not fully protected and the service was not adhering to the most up-to-date and effective care practices.

The registered manager failed to notify the Care Quality Commission as required, of a person having left the service unnoticed and having been returned by the police.

People's health and dietary wellbeing were supported. Some improvement had been made in the range of activities offered to people since the previous inspection. People's spiritual needs were provided for through clergy or church representatives visiting the home. People could choose to what extent they were involved in group or individual activities.

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

We issued Warning Notices to the registered manager and provider regarding three of the breaches. The registered manager is working with us with the support of the local authority care home support team, to

address the issues raised.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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.

Although people said they felt safe in the service, there were insufficient suitably qualified and competent staff available during the day and at night, to provide the support people required.

There were a number of health and safety and fire safety issues which had not been addressed.

Where people had been identified as at risk in some way, there was insufficient guidance for staff of how to act to minimise the risk.

We found inappropriate infection control practice in operation, which could expose people to a risk of infection.

There were gaps in the required records around medicines management, which could result in unsafe administration.

Is the service effective?

Requires Improvement

The service was not always effective.

Although people and relatives were happy with the care and support provided, staff induction was minimal and very basic and the national Care Certificate programme or equivalent for care staff, had yet to be introduced.

There were some gaps in staff training and staff performance appraisals were not up to date.

People's rights and freedom were not effectively protected because the registered manager had insufficient understanding of current legislation in this area.

The registered manager had insufficient understanding about the issue of consultation and who could lawfully give consent.

People's wishes and preferences were not always identified or respected in providing their care and support.

People's health and nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were generally happy with the approach of staff, although some told us they did not get on with all of the staff.

We saw positive and respectful interactions between people and staff.

Staff did not always effectively support people's dignity and privacy.

Staff did not always have sufficient information available to them in care plans to enable them to meet people's individual wishes and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's feedback about opportunities to make day-to-day choices was variable. Some people felt they had limited opportunity, while others were satisfied with the level of choice.

Care plans sometimes provided insufficient detail about people's needs and preferences and the level of support required. Although they were reviewed, they were not always effectively updated to ensure they remained current.

Although the range of activities and entertainment had been improved since the last inspection, there remained room for further development to meet people's social and emotional needs.

Is the service well-led?

Inadequate

The service was not well led.

People's views about the service were sought via surveys and in resident's meetings.

The registered manager did not have effective systems in place to monitor the operation of the service and had not made necessary improvements unless instructed to do so by external professionals.

Health and safety, fire safety and other concerns had not been addressed in a timely way.

The registered manager did not have sufficient knowledge and awareness of current legislation, which was reflected in aspects of current care practice, which was not up to date.

Key records were not sufficiently detailed or maintained effectively to ensure people's current needs were met with due regard to their wishes. Daily notes did not provide a full and accurate record of people's wellbeing, activities and daily lives.

Holly Grange 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.

This inspection took place on 14, 15 and 24 March 2016 and was unannounced on the 14th and 24th. This was a comprehensive inspection which was carried out by one inspector.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke with six staff members and the registered manager. Some people who use the service were able to give us verbal feedback about their experience.

We observed the interactions between people and staff at various times throughout the inspection and had lunch with people on the first day to help us understand their experience. We observed how staff supported people in the service to meet their needs. We spoke with seven people and four relatives during the inspection and contacted the local authority to seek their views.

We reviewed the care plans and related records for five of the people supported, including their risk assessments and reviews, and related this to the care observed. We examined a sample of other records to do with the home's operation including staff records, complaints, surveys and various monitoring and audit tools. We looked at recruitment records for three recently appointed staff.

Inadequate

Is the service safe?

Our findings

Some people were able to tell us they felt safe. People told us: "I feel safe here": "Oh yes I'm safe" and: "I feel safe, the staff are ok". Relatives told us people were safe from harm. One said: "[name] is safe and well looked after, I'm here a lot, if there were issues I'd see them" and another told us: "She is safe here and well cared for".

In two care records a risk or issue had been identified but there was no information provided about how staff should respond. For example, one person's risk assessment identified they were at risk of skin breakdown. However, there was no care plan in place to address this. Another person's risk assessment for skin integrity had recently been revised to a "high" risk of pressure sores but no plans were in place to reduce this risk. In other people's care files we noted that there was a record of the response to such changes in people's needs, although not always in sufficient detail.

It was not clear that staff fully understood the skin integrity risk assessment process. Some people's risk levels were increased significantly following a recent review by a health professional, who identified that previous assessments had been wrong. Although no skin breakdown issues were reported, people's previously inaccurately assessed risk levels meant that appropriate actions might not have been taken to try to prevent skin breakdown.

Where body charts had been completed to record bruising or other injuries, there was no evidence this had been followed up to try to identify the cause or explanation for the injury. No note was made on the chart of any treatment or when it had healed. Whilst the injuries noted were minor, they still required some follow up to identify how they had occurred and if any changes were necessary.

The service did not always ensure people's safety. When we arrived on the third day of the inspection we found the front door had been left ajar and unsecured. This meant that people supported by the service could have left the building unobserved and been placed at risk in the community, or unauthorised outsiders could have gained access.

The service had three bathing facilities, a ground floor shower, a ground floor seated bath/shower and a first floor hoist-assisted bath. We were told the first floor host assisted bath was the only fully-functional bathing facility in the home, because the ground floor shower/bath had been defective for over 12 months and was only be useable as a shower due to leaking seals. The ground floor shower was out of order and non-operational. Each facility had a recently added risk assessment on the wall reminding staff to test the water temperature before bathing/showering a person. However, there was no thermometer located in the ground floor bath/shower room to enable staff to test the water temperature. A thermometer was present in the first floor bathroom but no written records of temperature testing were being kept. The registered manager told us the bathrooms were fitted with thermostatic safety valves. However, there were no records of them being serviced or of regular hot water temperature checks to ensure they were working properly. The safety valve in the ground floor bath/shower room was exposed on the wall behind the bath/shower. It could readily be adjusted from cold to an excessively high temperature, which was too hot for the inspector to keep their

hand under the tap. This presented a potential risk of injury to people using the equipment, especially in the absence of a thermometer or any record of temperature checks. The shower hose was in a poor state of repair with the outer casing unravelling.

The registered manager had completed a fire risk assessment in 2010 which had been reviewed, most recently, in November 2015. The majority of identified issues had been addressed since then; however, some key issues were yet to be addressed. No individual evacuation plans had been written, in accordance with best practice, particularly for the two people on the first floor with limited mobility. The registered manager had not ordered any devices to aid evacuation via the stairs, for those who would require support to use them. The registered manager told us there was no emergency contingency plan in place in the event of foreseeable emergencies such as a failure of services, or the need for evacuation.

The registered manager had no date recorded for having attended medicines training. He was planning to undertake the future medicines competency checks of staff as part of the care certificate. The registered manager had also recently reviewed and updated the procedure relating to medicines management. He told us there had been no medicines errors since the previous inspection. The most recent local authority monitoring visit/review had also identified that the registered manager did not have the knowledge or skills to monitor, train or assess the competency of staff on medicines management. The registered manager said he and one further staff member were due to attend medicines training by May 2016. The registered manager was not, therefore, competent to monitor and assess the appropriateness of medicines management in the service, or the skills of staff in this area.

People were placed at potential risk of infection because no Legionella testing of the water supply had been carried out to ensure the water supply was free from this hazard.

These issues were a breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to properly assess and mitigate identified risks to people, had failed to use the premises and equipment in a safe way; had failed to ensure people's safety by using the premises safely or ensuring equipment was safe to use and had failed to ensure people were safeguarded from the risk of infection. The registered manager had failed to ensure that persons providing care or treatment had the competence or skills to do so safely.

No safeguarding issues had been reported regarding the service since the previous inspection in June 2014. However, during the period of inspection one person had left the building unobserved and been found and returned unharmed by the police. The service had not reported this to the appropriate authorities. When we asked the registered manager about this, he was unaware of the need to report it.

This was a breach of Regulation 18(2)(f) of The Care quality Commission (Registration) Regulations 2009. The registered manager had failed to notify the Care Quality Commission of an event requiring such notification.

Following the inspection, the registered manager submitted a retrospective notification of this event.

The service did not have appropriate equipment to sterilise commode pots. Commode pots, together with the home's toilet brushes and stands were being disinfected in the first floor bath. The use of the bath in this way was inappropriate, unhygienic and presented a potential risk of cross-infection.

The bath was full of hot water containing bleach. Although the bathroom had been locked by staff using the vacant/engaged bolt, this also presented a potential risk to people had they managed to gain entrance.

These issues were a breach of Regulation15 (premises and equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to ensure that equipment provided was clean, suitable for the purpose or properly used; and had failed to maintain appropriate standards of hygiene.

Staffing levels within the service were not sufficient to meet people's needs. Until recently only two care staff had been on duty throughout the waking day. The manager had identified that additional staffing was needed and pending recruitment, had been providing some additional daytime support himself. Rotas showed that some staff were working excessive and potentially unsafe hours. For example one person had worked four, thirteen and a quarter hour days, interspersed with three eleven and a quarter hour waking night duties in each 7 day period. Their employment contract stated a 37 hour week. Another staff member had worked 11 days without a day off.

The registered manager initially told us, and rotas showed that night time staffing was one person on waking duty and a second person sleeping in on call on the premises. However, when questioned further, the registered manager confirmed that the three staff who lived on site were not paid to work sleeping in shifts. The rotas were therefore misleading because they showed one staff member on sleep-in duty nightly in addition to the staff member on waking nights. Staff and people in the service confirmed there was only the one staff member on duty at night. This was potentially unsafe for up to 16 people and would mean that the single staff member might have to manage any incidents, accidents or emergencies alone.

These issues were a breach of Regulation18 (staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to provide or deploy sufficient numbers of suitably qualified, competent staff.

Some people were potentially at risk of neglect or receiving inappropriate care because their care plans were either not up to date or did not provide clear enough information on their needs. Three of the five care files examined had such gaps in the key information. In some cases, changes had been identified in evaluations (reviews) of the care plan, but had not been incorporated in the care plan itself. This meant that in order to obtain the full picture of someone's needs, staff would have needed to look in more than one place within the document. For example, one evaluation had identified improvements in a person's level of involvement in their own care, but this was not reflected in the care plan itself.

Support provided to people with their medicines was not fully compliant with national guidance. There were no records about how individuals preferred to take their medicines nor any individual protocols for 'as required' (PRN) medicines. These are necessary to describe the particular circumstances under which PRN medicines should be given to each individual. One person's care records noted a possible allergy to Penicillin but this was not identified within their medicines file.

These issues were a breach of Regulation 9 (person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to ensure that appropriate assessment, care and treatment was provided to meet people's needs and had failed to ensure that care and treatment was designed to meet people's preferences.

Most, but not all staff were able to explain how to safeguard people from harm and could explain their role in the event of identifying a concern. However, not all staff had attended safeguarding training, with five staff having no date recorded for this. The registered manager told us he was arranging this training imminently from the NHS Care Home Support Team who were about to commence a period of work to support and develop the service. Most staff knew how to record and report any concerns or injuries and were aware of

the whistle blowing procedure. Some staff, but not all, were confident the management would respond appropriately should any concerns arise.

We identified a potential health and safety hazard to people and/or staff which had not been addressed. The pivoting arm of the bath hoist was missing the retaining bolt, which had been replaced with a non-standard, unsafe fixing. The manager was asked to de-commission the hoist and seek a proper repair as a matter of emergency. The registered manager confirmed that the hoist was repaired two days after the inspection visit but had made the repair himself having been sent the missing part. We requested certification that the hoist was now safe to use, and that it should not be used pending this. Confirmation of this was then provided.

Staff had received fire safety training from an external company in November 2015. The fire brigade carried out a safety audit in February 2016. The registered manager told us the brigade raised no immediate requirements. However, a copy of the report provided following the inspection, identified several safety deficiencies as "Measures considered necessary", requiring action. These included the need to revise the emergency evacuation plan, provide individual evacuation plans for specific residents, physical fire safety improvements and additional safety equipment required. Records of in-house testing of alarms, and emergency lights showed these were regularly completed and equipment had been serviced.

The records of the majority of periodic service checks of systems and equipment, were mostly in order. The gas safety check had taken place recently and no record was available. However this was obtained during the inspection process and a copy supplied. No evidence of the periodic safety testing of the electrical installation was available. This was also identified by the fire authority. The thermostatic safety valves on the water supply to outlets had not been regularly serviced to ensure they were working correctly. The kitchen had recently been awarded a five star rating by the environmental health department.

Three people commented the call bell response was sometimes slow, but two others said response time wasn't a problem. One commented that the response was also slow at night. Some staff felt the staffing levels were not currently sufficient. On the second day of inspection (a Tuesday), the registered manager told us the rota for the current and following weeks were not yet written. This made it impossible to establish whether the staff on duty were as planned or not.

One recently appointed staff member's English language and communication skills were insufficient for them to be able to meet people's needs, communicate effectively with, or understand them. They were unable to answer some basic questions and had not read people's care plans. They were unfamiliar with people's needs. The registered manager said they were only employed, for the moment, assisting other staff by providing people with drinks and meals but no training or development plan was in place for them. However, they had sometimes supported people with aspects of personal care/toileting. The staff member said they had prior care experience with older people but had not attended any initial training in the service. We heard people in the service commenting that the staff member couldn't understand them.

The registered manager told us recruitment was sometimes difficult due to the village location and he had found it necessary to recruit all three recent recruits from overseas. No agency staff had been used by the home. The top floor of the service provided a shared three-bedroomed flat for three staff. The registered manager told us he currently had one full time care staff vacancy which was being advertised locally.

Recruitment records were not sufficiently robust to ensure that staff recruited were suitable. We examined the recruitment records for the three most recent recruits, one of whom had already left the service. Recruitment records were available although they were not held in a single location or in a consistent or robust way. The records confirmed that the required checks had been completed, including criminal records

checks, references and confirmation of identity. However the content of application forms was inconsistent and two of the three forms did not include the page requesting employment history. The registered manager had recorded this separately on a sheet of paper during interview, but it was therefore not part of the applicants signed declaration of their details. The recruitment histories only noted the year of employment which did not account for their full history. The records included translations of relevant overseas documents. The registered manager confirmed no test of recruit's literacy or communication skills were completed to identify whether they were sufficient to meet the needs of people and the service.

All but two staff had received recent medicines training. The registered manager told us there were no significant issues with medicines refusals and everyone could make it clear whether or not they were happy to take their prescribed medicines. The most recent pharmacist inspection took place in February 2016. When asked, the registered manager felt the visit had not raised any significant issues. However, the report identified a number of issues requiring action including some stock discrepancies, improvements to auditing processes and medicines practices; and the need for protocols for PRN (as required) medicines. The registered manager had devised an action plan which he was in the process of addressing although three matters remained outstanding.

Appropriate medicines administration records were in place, which provided an effective audit trail of medicines. Double signatories were obtained for any controlled drugs which were appropriately recorded in a separate log. People's medicines administration forms were accompanied by a photograph. Medicines were stored appropriately in a locked trolley and a separate drugs cabinet.

Requires Improvement

Is the service effective?

Our findings

Some people were able to give us verbal feedback about the support they received. People were happy with their care. One person said: "Staff are very good, I get on alright with them", adding: "It couldn't be better". Another told us: "The staff are wonderful, they have looked after me so well" and added: "I like it here, it's clean". Other people commented: "It's OK here, the staff are alright, but they sometimes take their time", and: "Care is very good, it's home from home, can't fault it". A relative described the home as: "Very good" and added they were: "Very grateful for what is being done". Two people identified specific (different) staff they did not get along with, but said they were happy with the other staff. A relative commented that the staff were: "Attentive" and added: "I find the place fantastic, nothing is too much trouble".

We saw that people and staff related to each other positively. Staff supported people to make some day-to-day decisions and they were encouraged to do things for themselves. Staff engaged well with people and offered assistance patiently, allowing them sufficient time to do things without being rushed, and care plans made some references to this. People were encouraged and prompted at times to help them remain focused, for example, on eating their lunch.

However, staff were not properly inducted, supported or trained to ensure they had the necessary skills to meet people's needs. Staff had been provided with a very basic induction to the service, which was not based on the national 'Care certificate' competencies. No staff had yet commenced the 'Care certificate' national qualification. The local authority identified this at their last monitoring visit and were providing some guidance on how to implement a Care Certificate-based programme.

The training records provided, showed that core training had been provided to most staff following recent visits from the local authority, who had identified training shortfalls. The local authority had recently provided a medicines training update to five staff. Some staff still required core training in key areas to ensure they had the knowledge to carry out their duties effectively. For example, four staff required safeguarding training, three had not attended medicines training and one required moving and handling training. The most recent recruit was not yet listed on the training record and had not yet attended any training or formal induction.

Records showed and staff confirmed they attended supervision meetings every two months to discuss their work. The registered manager acknowledged he was "behind" with staff annual performance appraisals. Only one staff member had an appraisal within the last 12 months. The others had last taken place in 2014.

These issues were a breach of Regulation18 (staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to ensure that staff received appropriate support, training, development and appraisal to carry out their duties.

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

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager did not have a clear understanding of the requirements of the MCA or the associated Deprivation of Liberty Safeguards (DoLS). 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 procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

For example the manager told us that all of the people supported had capacity for decision-making and no DoLS had been applied for. However, he confirmed that no-one would be able to leave the home safely unaided. Indeed he told us he would be using a bolt on the front door to prevent this, following one person being returned recently by the police, having wandered out of the service. There was no evidence that this had been discussed with people in the service. He did not fully understand the implications of this, that it might require mental capacity assessments and DoLS applications for those of the people supported, who lacked capacity to consent. The local authority had identified this issue and were in discussion with the registered manager about it.

The registered manager told us that until recently one person had been using raised bed-sides at night which he said had now ceased. However, he was unclear whether they had had capacity to consent to their use. No record of a capacity assessment, best interest discussion or of the decision making process was available. The registered manager said the person was now using a lowered bed, following discussion with their family. The registered manager told us one person was currently using bed sides, because they were "restless at night". He told us the person had capacity and had consented to their use, and discussions about their use had taken place with family. There was no record available of the decision making process to establish whether the potential restraint of the person or the 'consent' obtained was lawful.

Another person's care plan identified the need to place a pressure mat alarm next to their bed to alert staff in the event they got up during the night. This was no longer required, according to the registered manager, but the care plan had not been amended to reflect the change. This could lead to an inappropriate limitation on the person's freedom of movement if the mat was still placed there by staff, in accordance with the care plan. It was also not clear whether appropriate consent had been sought for its use as this was not recorded within the file.

A 'consent to care' form was on some people's files, signed either by the person themselves or their representative. However, in the absence of any related documentation, (such as power of attorney or capacity assessments), it was not always clear whether the 'consent' had been obtained lawfully.

These issues were a breach of Regulation 11 (consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to ensure that care and treatment was always provided with appropriate consent or with due regard to the Mental Capacity Act 2005.

Staff described how they consulted people and sought their consent prior to the provision of day to day care or support. People we spoke with told us staff, generally, sought their consent in the course of providing day-to-day support. One person said they: "Check and consult" and another commented that staff: "Ask first" before providing support.

People were complimentary about the food. Four people said: "The food is good". One said the staff: "Make sure I have drinks regularly". A relative described the staff as "Accommodating" around their family member's food wishes". One main meal was offered at lunchtime. The registered manager said that an

alternative would be provided if staff knew the meal was not liked by someone, or if they asked. People said they were asked if they liked the main meal. Daily notes indicated that people had been given snacks and refreshments outside of mealtimes.

People and relatives felt the service looked after their health needs well. One said: "They will get the doctor in if necessary" and another observed: "The staff pick up on issues and illnesses". One relative commented that staff: "Keep on top of it [health] and the GP is here weekly". Another said "healthcare is sought promptly". We saw that external healthcare professionals had been consulted including GP's, community nurses, the memory clinic and community mental health services.

One person had been assessed as being at risk due to low food/fluid intake and their food intake and weight were monitored, showing their weight to be stable. The advice of the speech and language team and a dietitian had been sought about their needs in the past. The registered manager told us one other person occasionally refused the meal offered but this was addressed through the offer of an alternative. The GP was aware of their needs as they had also declined medical tests and they had also been seen by the mental health team. A multidisciplinary meeting was due to take place involving the person's next of kin, but it was not clear if the person themselves would be present.

The standard of décor and repair of the premises was variable with some areas in need of redecoration, including patches of water damage on walls. The registered manager said that one particular corridor was about to be redecorated. The carpet in another area of corridor was very worn and in need of replacement. The three bathing facilities provided were in varying states of disrepair and the main bathroom had areas of discoloured grouting around the bath. On the first day of inspection the temperature of the two conservatory areas, one of which is the dining room, was too low. We heard three people at lunchtime commenting on their discomfort because the dining room was cold, and staff also said it was cold at times. The remainder of the home was at a satisfactory temperature apart from the external laundry building which was also very cold, but was not used by people in the home.

Requires Improvement

Is the service caring?

Our findings

People and relatives were generally happy with the caring and friendly approach of staff. Their comments included: "The staff are gentle": "Staff are kind" and: "Staff are very kind to you, they treat you properly". Two people said they didn't get on with particular staff but gave no specific reason for this. We saw staff engaged positively with people they were supporting. They greeted people by name when they saw them and spoke pleasantly with them. We saw that when people were in their bedrooms, their call bells were within reach.

One person told us: "Staff look out for my dignity, they cover me up, and knock on the door". Another said: "They are good with dignity, they wait outside the toilet for me". A relative told us the staff managed people's dignity well and described them as "Discreet". Another relative said: "Personal care is done with dignity and staff don't draw attention to issues".

People each had their own bedroom and bedrooms would only be shared where it was people's specific choice, which helped to support their privacy and dignity. Staff explained that personal care was carried out behind closed doors and people were covered as much as possible while being supported with personal care. They said they knocked before going into people's rooms and used people's preferred names. Staff also described how they encouraged people to do whatever self-care they could manage and encouraged people to mobilise independently whenever possible. People fed themselves, with staff assisting some people with cutting up their food. Some people were provided with special crockery to assist them to continue to eat independently. Ten of the sixteen bedrooms had ensuite toilets which supported people's privacy and dignity.

Staff acknowledged that at times people received personal care support from male staff, even though they had stated a preference not to, or were known not to like to be supported by males. Staff told us of at least two people who had stated they did not wish to receive personal care from male staff. People's files did not always record whether this question had been asked, so people's preferences were not always recorded. A male staff member said he had provided personal care support to some people who did not want this, as there had been no other option at night. A male staff member was the sole staff member on duty three nights per week, which meant people had no choice about the gender of the staff providing their personal care support and cross-gender care would be inevitable.

Examination of the daily notes for one person known not to want male care staff confirmed this. The records showed that the person's level of challenging behaviour was often higher when support had been provided by a male staff. However, this had not been identified and no steps had been taken to address the issue of cross-gender care.

We also noted on two occasions that staff failed to knock on people's bedroom doors before entering, which failed to respect their dignity and privacy. We noted some inappropriate language used to describe people and their behaviour within their care notes. For example, the use of terms such as: "Very rude and unhelpful": "She was rude as usual and wanted female service" and: "rude and unpleasant as usual", which were disrespectful.

This was a breach of Regulation 10 (dignity and respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to ensure that people were always treated with dignity and respect and had their privacy respected.

People's files noted how they wished to be addressed and two people told us staff addressed them by their preferred name. The care plans contained terms like "encourage", "prompt and guide" and "minimal assistance and prompting, so staff were guided to what degree each person required support. One person's care plan noted: "Involve [name] in decision making and give her control of how she wants to present herself", which also suggested staff involve people in their own care. Other comments suggest staff should actively encourage people with self-care. One care plan noted: "Provide praise and encouragement when needed". Some care plans also noted people's wishes at end of life and who they wished to be involved in decision making at that time.

However, people's wishes and preferences were unlikely to always be met because care plans included inconsistent and insufficient information about them. For example, information about people's preferred times to get up and go to bed, and details of daily routines were not always present. People told us they tended to get up or go to bed when staff called them or suggested it.

The registered manager told us people's care plans were reviewed with them or their relatives but this was not often evident from their care records. Reviews mostly took the form of periodic evaluations of parts of the care plan by senior staff, and there was little reference to the involvement of, or discussion with people themselves. Some files contained copies of local authority led reviews. The registered manager said people were all able to make some day-to-day choices and decisions about their lives and care. Staff described how some people were offered choices between limited options to enable their involvement, where they would not cope with a wider range of options.

The registered manager said none of the people currently went out to places of worship although two people used to. He said their spiritual needs were addressed by visiting clergy. A vicar visited the home monthly and seasonal services were also held. One person had individual representatives of their church visit them periodically.

Requires Improvement

Is the service responsive?

Our findings

People's care plans reflected, to some degree, their likes and preferences, and were supported by other relevant documents like risk assessments and any specialist healthcare advice obtained. They identified that people required support, but were sometimes not explicit enough about the level of support the individual required. For example, one person's care plan said: "Staff to support [name] in maintaining her safety around the home". However, there was no detail about what this meant for that person. Sometimes there was information about how to support an aspect of care within the care plan evaluations, but it had not been included in the actual care plan. Some parts of care plans provided a more appropriate level of detail to enable staff to respond to people as individuals, but this was variable.

Senior staff reviewed the care plans periodically to ensure they still met people's needs, noting "evaluations" on the back page of each of the individual sections of the plan. However, information obtained from ongoing reviews and risk assessment updates, was not always included within care plans. This meant staff might not always be responding to changes in people's needs. Issues evident from people's daily notes did not always appear to have been considered when reviewing care plans. For example the escalation in one person's challenging behaviour when personal care was provided by a male staff member.

People were supported and enabled to make some choices about their day-to-day lives, but there was room for further improvements in this. People's feedback varied about the level of day-to-day choice available to them. One person said: "I don't make many choices". Some people said they chose things like the time they got up and went to bed, while others suggested they basically did so when it was suggested to them. Most people were aware they could have an alternative to the main meal offered if they wished and had chosen whether to take part in activities or not. One person said there was "sometimes" a choice of meal offered. Another person said they chose not to go to the lounge and told us they preferred: "Reading, writing and being on my own". Another person told us they had chosen to remain in their bedroom, apart from mealtimes and activities.

There was no written plan or poster of upcoming activities. The level of activities provided to people had increased since the last inspection, largely due to regular visits by the relative of a previous resident who provided various activities two or three times per week from 1-3pm. The registered manager was designing an activities board to post these and showed us the early stages of this. We saw the results of some Spring-themed craft work carried out with people around the home. The activities offered included cards, quizzes, bingo, ball games crafts, colouring and occasional outside entertainers. The registered manager told us about other one-off events booked in the future.

However, some people would benefit from staff having more time to spend with them one-to-one, particularly those who preferred to remain in their bedrooms. Staff told us they were often too busy but one said they: "Did some games and quizzes with people and sat and chatted". One person told us the staff were friendly but were always busy and did not have enough time to chat with them in their room apart from when cleaning or making the bed. Some people told us they joined in with the activities provided, others said they preferred their own company and chose to remain in their bedrooms much of the time. One said

they didn't enjoy being in the company of other people and added: "There wasn't enough entertainment". Another said: "I go along and join the activities" and told us about taking part in bingo and quiz sessions. Another said: "I don't want to do activities, it's peaceful in my room" and added that: "Staff will sit down and talk when they have time". Relatives said the level of activities was improving and told us about some of the activities provided. One relative said: "[name] absolutely loves it and adores the bingo and crafts".

The service had a complaints procedure which was normally posted in the entrance hall but had been taken down to be updated. It was replaced during the inspection. People told us they knew how to make a complaint if necessary. One person said: "I've never had to make a complaint, but I would complain if I needed to". Other people said they had not had to complain and one added they would tell the manager if they weren't happy and: "He'd sort it out", and a relative said the same. The complaints log indicated five complaints since the last inspection and noted that appropriate action had been taken to address them.

Inadequate

Is the service well-led?

Our findings

The service was not well led. There was no effective system for the ongoing monitoring and review of the operation of the service. The need for a management monitoring system had been highlighted to the registered manager at the last inspection in 2014. In the interim he had begun to use a monitoring format which consisted largely of tick-box checklists rather than any evaluation of the effectiveness of the service. The registered manager acknowledged the inadequacy of the format and had not been completing it fully. However he had not sought a more suitable document or process to address this. The registered manager told us he had carried out unannounced spot check visits but had no records to show these had been done. There was no current service development plan in place, the previous one having expired in November 2015. Following the inspection, the registered manager produced a one page development plan for the year to December 2016. The registered manager had also failed to notify the appropriate authorities about a missing person event which occurred during the period of the inspection.

The registered manager had failed to identify or address a range of health and safety-related issues which were identified at this inspection and had therefore not fulfilled his legal duties in relation to keeping people safe. This included potential infection control issues, defective equipment and inadequate safety checks.

The registered manager had not reviewed the quality and content of care plans, daily notes and other records. Issues we identified, should have been identified by the registered manager and acted upon. For example, the use of inappropriate and unprofessional terminology within daily notes and the gaps and omissions in care plans.

Records, including care plans and risk assessments, were inconsistent, sometimes contradictory and lacked detail in key areas. Rotas were misleading and inaccurate or were not available, so it was not possible to accurately identify who was supposed to be on duty. Daily notes were only made by staff on the early and night shifts. No regular records were made of people's needs, activities, or visitors throughout the afternoon and evening period. This meant there was no record of the care given or of people's wellbeing throughout these periods to provide continuous observations and provide for the prompt identification any concerns. This had also been identified as an omission by the local authority in their recent monitoring visits. The registered manager did not appear to understand the need for recordings of people's experiences throughout the day and night.

The registered manager was not fully aware of the recent changes to regulations around duty of candour (openness when things have gone wrong) and the requirement to display the rating which would result from the inspection. He was not able to demonstrate sufficient understanding of The Mental Capacity Act 2015 and the associated Deprivation of Liberty Safeguards. He did not demonstrate sufficient understanding of the legal position around consent and mental capacity. This meant that people's wellbeing, rights or proper communication with others might be compromised.

Overall, we found the management of the service to be largely reactive rather than proactive. Internal management monitoring was inadequate. Actions to address obvious issues and shortfalls had been limited

or had not been taken until problems were identified by external professionals. The registered manager tended to minimise the importance of issues that had been raised by external professionals such as the pharmacist and fire officer. For example, the shortfalls in staff training and fire safety. This meant that people were not fully protected and the service was not adhering to the most up-to-date and effective care practices.

These issues were a breach of Regulation 17 (good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to establish effective systems to assess, monitor and improve the quality and safety of the service. He had failed to assess, monitor and mitigate risks to people's health, safety and welfare and failed to maintain accurate and complete records in respect of service users. He had failed to effectively evaluate and improve his practice in response to information available to him in relation to the performance of the service.

The local authority had identified a range of concerns about the service following a review in January 2016 and provided the registered manager with an action plan to address these issues. They continued to visit, support and monitor the registered manager's progress on the action plan. The plan identifies many of the same issues as this report as well as those related to the service's contractual obligations to the local authority for people whose care is funded.

People and relatives were positive about the service and said they got on well with the registered manager and staff. The registered manager was present in the service daily. This meant he was available to people and relatives. It was evident he knew people well and they knew him. One relative commented that the service was improving.

A survey of people and relative's views about the service had been sent out in February and March 2016. Nine responses had been returned to date, indicating almost all positive feedback. The previous survey in 2014 had also been positive and action had been taken in response to the two issues that were raised, about activities and the laundry provision.

Team meetings and resident's meetings had each taken place approximately every two to three months and were minuted. The resident's meeting minutes noted relevant topics such as activities, redecoration and food.

Staff feedback about team spirit was mixed. Some felt there was a good spirit in the team while others thought it varied at times, depending who was on duty. Some staff felt that issues had not always been addressed when they had raised them with management. One staff member was not aware that team meetings took place.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to notify the Care Quality Commission as required, of a person having left the service unnoticed and having been returned by the police.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Insufficient information was available about people's preferences around medicines and how 'as required' medicines should be administered. information about one person's medicines allergy was not included in their medicines record. Records of decision making processes, people's mental capacity and whether others had power of attorney on their behalf, were insufficient. In some cases people were supported by staff in contravention of their gender preferences or these were not known.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People sometimes received personal care from male staff against their known wishes. Not everyone's preferences regarding the gender of staff supporting them had been sought. Some inappropriate language had been used to describe people in their records, which was not

respectful of their dignity. Staff sometimes failed to respect people's dignity and privacy when entering bedrooms.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to aspects of their care was not always obtained or may not have been obtained from others legally, on their behalf.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff during the daytime and at night was insufficient to meet people's needs and provide for their reasonable wishes. Some staff were working excessive hours which could put people at risk. Staff received inadequate induction and training and performance appraisals were not up to date.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Insufficient staff were provided during daytime and at night to ensure people's needs were met. Care records were not always up to date or contained insufficient information. Potential risks to people's wellbeing had been identified but not acted upon. People's safety and security were not always maintained. Health and safety and fire safety hazards had not been addressed. A person had left the building undetected recently and the front door was found open during the inspection.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Insufficient fully operational bathing facilities were available and those present were not properly maintained, properly used or suitable for their use. People were put at risk of harm from infection because the home did not have appropriate equipment for sterilising commode pots.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had not acted to address identified issues and had failed to monitor the service effectively so as to identify potential issues. The registered manager had failed to address his responsibilities under health and

safety legislation. The registered manager had failed to notify the care quality commission of a notifiable event. Care records often lacked sufficient information or were not kept up to date. Staff rotas were inaccurate or not available in a timely way.

The enforcement action we took:

Warning notice