Mr & Mrs A B Satari

Castle Mount Residential Care Home

Inspection report

54 Manygates Lane
Sandal
Wakefield
West Yorkshire
WF2 7DG

Tel: 01924251127

Date of inspection visit:
21 January 2016
04 February 2016

Date of publication:
26 April 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 21 January and 4 February 2016 and was unannounced. The service was last inspected 23 August 2013. At that time the service was not meeting the regulations in relation to care and welfare of people using the service and staffing arrangements. At this inspection we found there were still issues with staffing and with the care and welfare of people using the service.

Castle Mount is a residential home providing accommodation to a maximum of 14 people. There were 13 people living there at the time of our inspection. Accommodation is provided over four levels with access provided between levels by use of several stair lifts. Access to the front is via several stone steps and access to the rear is level access.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The home had a registered manager who has been registered with the Care Quality Commission since 02 November 2012. 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. However, the registered manager had a full time job in addition to this role and was not able to dedicate the necessary time to ensure the service was meeting its regulatory requirements.

The people who lived there and their relatives told us they felt safe living at the home and the staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and

they knew the procedure to follow to report any incidents. However, incidents were not always recognised or reported, which placed people at risk of harm.

We found the service had not adequately assessed the risk for the people who lived there in relation to the environment and the use of equipment such as the stairlift, use of bed rails, nutrition and some medicines. As the risks had not been appropriately assessed, there were no plans in place to reduce the risks involved in these areas. For example no one at the home had their own evacuation plan to detail how they would be supported in the event of an emergency evacuation.

Recruitment procedures ensured staff were suitable and safe to work with people. Staff received the induction, training and support they required to carry out their roles and meet people's needs. Although there were no records of on-going competency assessments.

The registered manager did not fully understand the legal requirements relating to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) although had received recent training. No DoLS authorisations were in place and no requests for authorisations had been sent to the local authority for authorisation even though we found people at the home had restrictions in place to their liberty.

We found the areas of the home were not clean or well-maintained and there was no urgency to replace faulty equipment such as dishwasher, washing machine, dryer and seated weighing scales. Following our inspection these issues were promptly resolved.

People's rooms were personalised and they could choose how they wanted to be supported such as what time to go to bed and what time to get up in the morning. People told us how much they liked living at the home and relatives told us they were involved in their relations care planning.

We found staff supported people with kindness and compassion and we observed they respected people's dignity and privacy.

There was a complaints procedure and we were told there had been no complaints for the past two years. However, during the inspection we were made aware of complaints which had not been recognised as complaints and there was therefore no record that they had been responded to appropriately and to the home's procedure but also there had been no learning from the experience. We found this was a breach in regulation as complaints were not being recognised or responded to appropriately.

There were some systems in place to monitor and assess the quality of the service such as audits of rooms and fire safety, and a whole service audit had been completed by the registered manager in September 2015 but these systems were not effectively used to identify and address areas for improvement to ensure that the quality of care continually improved.

Accidents and incidents were recorded, however there was no overall analysis to identify trends or themes and consider 'lessons learnt' to reduce the likelihood of re-occurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People told us they felt safe and staff had been trained and understood safeguarding procedures. However, incidents were not always recognised or reported, which placed people at risk of harm.

Risk assessments were not in place to ensure risks were reduced and people were protected from harm. There was also a lack of awareness around what constituted a risk to enable plans to be put in place to reduce the risk.

The environment was not thoroughly clean, or well maintained and we there was no systematic and robust way of ensuring actions had been completed around maintenance issues.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were inducted, trained and supported to ensure they had the skills and
knowledge to meet people's needs.

The legal requirements relating to the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLS)
were not being met.

People were supported to access health care services to meet their individual needs.

Is the service caring?

Good

The service was caring.

People told us how kind, caring and compassionate the staff were and they liked living at Castle Mount.

People were relaxed and comfortable around staff.

People's privacy and dignity was respected and maintained

Is the service responsive?

Requires Improvement

The service was not always responsive

There was out of date information in people's care files which could have a detrimental impact on their care if followed.

Some people living there were comfortable with the level of activities in the home, but other people told us they wanted more stimulating occupations.

Complaints were not always recognised, recorded and dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager had a full time job and was not able to give the home the necessary time to monitor and improve the quality of care provided at the home.

Audits and systems were not robust and were not present at the home on the day of our inspection.

There was no effective leadership at the service.

Castle Mount Residential Care 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 21 January and 4 February 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert-by-experience with an expertise in caring for an older person. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had received from the provider such as notifications and information in the Provider Information Return. The registered provided 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 also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They had no recent information to inform our inspection process.

We used a number of different methods to help us understand the experiences of people who lived in the home. We observed the lunch time meal experience in the communal dining area and spent time in the communal lounge.

We spoke with six people who lived at the home and three visiting relatives. We also spoke with a visiting General Practitioner. We reviewed five care files and all the documentation available in relation to the management of the home.

Inadequate

Is the service safe?

Our findings

As part of our inspection we asked people who lived at Castle Mount and their relatives whether they were safe. People who lived there told us they felt safe. One person said "Oh yes, I feel quite safe. I wouldn't like to be anywhere else." Another said "I feel quite safe here. I'm very well looked after. I feel like I'm on a magic carpet. I don't have to plan my own meals or any of the paraphernalia of being at home" We were also told "I know they're not all good, care homes. But this one is good. Fit for the queen." A relative of one of the people living there told us "The main thing is they're well looked after, safe and happy." They told us their relative seemed happy and much better than when they were at home.

The deputy manager told us there had been no recent safeguarding issues at the home and no one at the home had behaviours that challenged others. They told us they would report any issues straight away through to the local authority. We spoke with a carer who was able to describe the signs of abuse which they might find in a care home and what they would do about it. They confirmed they had received recent training and were confidently able to describe to us what they would do if they suspected abuse was occurring. However, there was a lack of awareness amongst the staff that using poor manual handling techniques might constitute abuse and we observed two people being assisted with inappropriate techniques during our inspection. In addition, we referred one person to safeguarding following our inspection, as this person was immobile and had been moved to an upstairs room with no means of accessing the ground floor or to exit the building and there was no accurate explanation or record as to how this person had been moved to the upstairs bedroom. We also referred a second person to safeguarding in between our two inspection visits following information of concern we had received from a third party. We discussed this matter with the registered manager who had not recognised this matter should have been referred to safeguarding. This demonstrated a lack of awareness around safeguarding which could place people at risk of harm.

We reviewed five care plans for evidence that risk was assessed and managed appropriately at Castle Mount. We found evidence in two of the care files, bed rails were utilised to keep people safe but there were no associated risk assessments to support the use of the bed rails. We were told hourly safety checks were carried out during the night to check people were safe using the rails. However, we were concerned that in one person's case this was a restriction to their liberty to keep them in bed, and other solutions such as motion sensors might potentially be a safer option but as the risk had not been adequately assessed, no other solutions to this person's safety had been considered. We discussed this with the registered manager following our inspection and they confirmed they had downloaded an appropriate risk assessment from the Health and Safety Executive website which would be put in use for all people who were supported with bed rails and they would readdress the risks associated with the bed rails.

We identified two people from the four care files we reviewed as having lost weight and requiring support with eating and drinking. We saw no evidence of appropriate planning or specific risk assessments. In addition the seated weighing scales were broken so these people could not be weighed. This was raised with the deputy manager who told us the scales had been broken for several months. This demonstrated a failure to assess and reduce the risk in relation to ensuring people at risk were monitored for weight loss.

In one person's care file we found no risk assessment in place for Lorazepam, which was used when the person became agitated. This demonstrated a failure to understand the inherent risks of medicines of this type and the requirement to risk assess to reduce the likelihood of harm.

The home had no lift between floors and people accessed the different floors via stair lifts. During our inspection one of the stair lifts was not working as one person who lived there had used it and not sent it back to its charging point. There was no system in place for staff to regularly check stair lifts were on charge. We found all the stair lifts were dirty and a number were missing the remote control. The most frequently used stair lift had loose carpet on the foot rest and one had a dirty and loose safety belt. As all the floors were accessed by stair lifts, risk assessment should be in place for each person utilising the stair lift detailing whether the person was safe to use the stair lift on their own, risk associated with the use of the lap belt, and how to summon assistance if the stair lift stopped mid-way. We found no risk assessments in the files we reviewed and the registered manager and deputy manager were unaware who was actually using the stair lifts. For example, during our inspection we observed one person using the stair lift without the lap belt. When we raised this with the deputy manager and the registered manager they told us this person usually walked up the stairs. We shared our concern regarding the lack of risk assessments with the registered manager after our inspection and explained their responsibility in relation to managing risks at the home. They told us they would action this immediately.

During our inspection we observed moving and handling procedures which were not in accordance with good practice. For example, we observed two people who lived there were assisted to stand from their wheelchair by staff utilising an underarm lift. In one situation we observed one member of staff discreetly and encouragingly place a handling belt around the person to be assisted. When it was time to move the person, the second carer dismissed the use of the handling belt and told the first carer it was not needed to move the person the short distance from the wheelchair to the arm chair and proceeded to assist using an underarm lift. We observed a second incident of this type of lift assisting a person from wheelchair to arm chair. In addition the person was presented with a zimmer frame to pull up on to reposition them self in the chair, this was not in accordance with good practice.

We found information in two care plans which were inaccurate relating to moving and handling. The records for one person stated they required the use of a stand aid and two carers to stand when in fact they were dependent on a hoist for transferring. This meant that there was a risk that people could be handled inappropriately due to the lack of accurate detail in the moving and handling care plan.

We saw records which showed moving and handling equipment was regularly tested to ensure it was safe to use and the stair lifts were under a maintenance contract. The home was in the process of having emergency fire door closures fitted to the downstairs doors off the kitchen and living areas on the instruction of the fire officer.

We found no personal emergency evacuation plans (PEEPS) in people's care files. The deputy manager told us "I spoke to the fire officer about that. As it's a small building and it's a no evacuation policy, they said as long as people are behind two fire doors, we don't have to do a fire risk assessment for each person." We spoke to the fire officer following our inspection who told us this information was not correct and each person required their own fire risk assessment and evacuation plan and the advice about being behind two fire doors related to the length of time the service had before evacuating people, and not that it meant no evacuation. When we compared information regarding people living in the home and their mobility requirements, and the information the fire officer had been given, we found the information was inaccurate and did not tally. For example, one person who we observed as requiring hoisting was recorded on the information given to the fire officer as mobile. Other people living at the home were not on the list. This

meant that the people living there were at risk in the event of a fire as there was no system in place to ensure the safe evacuation of the people living there. In addition, one person living there was cared for in bed and had no means of using the stair lift to access the ground floor and exit the building.

There was no fire evacuation policy on site and staff had not received any fire evacuation training as the home had a non-evacuation plan. A newly appointed member of staff told us that they had not had any training related to fire safety and did not know about the fire alarms.

This breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had not assessed the risks to people's health and safety and had not taken all reasonable steps to ensure the health and safety of people using their services by appropriately managing the risks.

As part of our inspection process we look to see how the service manages medicines. We found the medication policy dated 2014 used out of date information and did not contain the most recent national guidance on managing medicines in care homes. On the day of our inspection the deputy manager was undertaking all aspects of medicines management. We inspected the ordering systems, supply, storage, stock control, administration, training and auditing of the home's medication. The home was supplied by a local pharmacy and used a monitored dosage system. We saw that the deputy manager checked the supplies and recorded the new stock on the Medicines Administration Record (MAR) charts. The pharmacy also conducted the training of care staff. Ten staff and the deputy manager were trained to administer medicines but the home did not undertake any formal competency reassessment, nor did not see any reference to annual competency checks for staff in the medication policy. We asked the registered manager about this and they told us they checked the staff competency to administer medicines over the CCTV. This would not comply with national guidance on assessing competency in the management of medicines.

There was no clinical or hand washing facilities as the medication trolleys, the CD cupboard and drugs fridge were stored in a corner of the dining room. During our visit we observed the administration of medicines to people who lived at the home and saw that it was effective. The fridge temperatures were monitored and recorded daily and we saw that they were within normal limits. We checked the controlled drugs which were in order and stored in a locked cabinet on the wall.

The scheduled tablets were dispensed in individual sealed pots for administration throughout the day. Whilst there was a pictorial representation of all the tablets on the MAR sheet the majority had no photograph of the person for whom they were prescribed. We found that staff had a basic understanding of the reason for most of the tablets and solutions and that pharmaceutical information was kept in a folder. We observed the checking and signing the MAR sheets and the appropriate and safe administration of the medicines, but the application of cream to one person's knees was undertaken in an undignified way and in full view of all everyone sitting with them in the communal lounge.

We undertook a check of boxed medicines. We had some concerns related to stock control and management of these drugs. The PRN (as needed) medicine we checked had no protocol of GP review date for their use despite this being stated in the medicines policy we reviewed. In addition there was no record on the reverse of the MAR sheet related to the rationale and number of tablets administered for these types of medicines. There were also problems with stock control with some medicines not being delivered in a timely manner and a drug error that occurred on the morning of our inspection. We also overheard the deputy offering an alternative pain control drug as an alternative to that prescribed.

This breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

as the registered provider had not assessed the proper and safe management of medicines or ensured there were sufficient quantities to meet the needs of the people living there.

We asked care staff whether they had enough staff to support the people who lived at Castle Mount. All the staff we spoke with told us there were enough staff. One member of staff told us "Yes, there is enough staff. There are busy times" The deputy manager told us they did not use agency staff. If a member of staff rang in sick they would contact existing staff and offer them additional shifts. They told us they used a dependency tool to determine staffing levels which was discussed in the weekly meeting with the registered manager. However, we saw evidence in care files that these dependency tools had not been accurately completed and they contained out of date and incorrect information and we saw no evidence these were used to determine staffing levels.

The deputy manager told us they had recently increased the number of waking staff during the night to two following the increase in dependency levels of one person. They also told us there was always a member of staff on call who would attend the service if a situation arose which required additional staff. We reviewed the staffing rota for the four weeks prior to our inspection, which showed the number of staff on duty but did not define the roles of the staff on duty. The deputy manager told us there were two care staff and a senior member of care staff on each morning, which we observed to be at the location during our inspection. They told us the home employed a cleaner during the day on weekdays and care staff undertook the cleaning at the weekends.

We reviewed the recruitment records for three staff. They had all had checks undertaken with the Disclosure and Barring Service (DBS) before they started work at the home. DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. The deputy manager told us all new staff were on a temporary contract as relief staff before being given a permanent position to ensure they had the right skills and behaviours to support the people who lived there

As part of our inspection we reviewed the accident and incident records. We found one of the people whose records we reviewed as part of our inspection, had four falls in July 2015. One of these falls resulted in a fractured limb and the person was admitted to hospital. This was not recorded on the accident and incident form, and the home had not notified CQC or RIDDOR of this accident.

The home employed one cleaner during the week. At the weekends and other times carers were expected to undertake all the domestic work. Consequently we found a number of problems with the cleaning of the home and the maintaining of washing facilities. Whilst there was a schedule for room cleaning which was expected to be undertaken daily, issues such as high dusting and carpet cleaning were in need of attention in all areas. We found windows and ledges were dirty and mouldy, one staff toilet near the kitchen was particularly dirty with large amounts of sediment around the fan and on the lampshade. We found dispensers broken, hand towels missing and a lack of hand gel the people and carers to use. We raised this with the registered manager who told us they would action this immediately.

The deputy manager told us an infection control audit had been conducted by the health authority the previous year but they had no information to share with us except there had been an action plan but they had not been back since. However, following our inspection we spoke with the infection control team who told us they had visited on 03 March 2015 and again on 14 August 2015 to review actions highlighted at the previous visit but as no there had been a lack of progress against the action plan, they were planning to revisit the service.

Requires Improvement

Is the service effective?

Our findings

People told us they enjoyed the meals at Castle Mount. One person said "The food is lovely. Sometimes I need things cutting up, but mostly I can eat alright. My favourite is fish and chips. They do it once a week. They do a really good fish and chips." Another person said "The food is very good. You can have as much as you want. You get a couple of choices and you can have Horlicks at night with a couple of biscuits. I'm not one for supper, but I do like Horlicks and biscuits." One relative we spoke with said their relative had put on weight since they came to live there.

There were three large tables in the dining room, laid with table cloths and place settings. There was a fruit bowl on the sideboard with bananas and oranges in it for people to help themselves.
Staff asked people if they wanted help cutting their food up and encouraged people to eat. Service was fairly slow. One person had not received their main course when several others were already on dessert. No one was rushed and a couple of people remained in the dining room eating for some time after others had left. Staff were pleasant, encouraging and present. One person who lived there started spluttering during the meal, and two members of staff responded straight away.

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.

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 the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection there were no authorisations in place and the deputy manager told us no one at the home was deprived of their liberty. However, during our inspection one of the people we observed during our inspection had restrictions in place to their liberty to ensure they were safe. We found no records to evidence either a capacity assessment or consideration that this person might be restricted or deprived of their liberty. The deputy manager had recently undertaken training in the Mental Capacity Act 2005 and DoLS and but was unable to explain to us how recent case law had been applied to people living in the home. We spoke with the registered manager after our inspection who had also attended training. They were not able to describe the test to determine capacity, or the principles of the Mental Capacity Act 2005, and we saw no capacity assessments or referrals for deprivation of liberty authorisations at the home. The home had not applied the outcomes of their learning or literature to the people living at the home and this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had concerns relating to the maintenance of the environment and the safety of the environment in the event of a fire. The fire safety issues were to be addressed separately by the fire service who will be issuing an

enforcement notice to improve the safety of the environment in the event of a fire. During the inspection we found issues with the environment such as some light bulbs not working in key areas, some rooms were cold, seated weighing scales were not working, the computer and printer were both broken, the dishwasher had not worked for four years. One washing machine and the dryer were not working and we observed wet laundry was being dried on a radiator and on folding portable drier in hall way. Windows in loft rooms had no restrictors. We were told these had been taken off to fit blinds and the handy man would be refitting these the following weekend but at the time of our inspection we saw no evidence to support this and neither registered manager or deputy knew about the recommended restrictors for use in care homes. The maintenance book was not present and we were told by the deputy manager, the maintenance person had taken this home. The registered manager told us in an interview after our inspection that the window restrictors had been fitted and all the issues we found at inspection were being addressed immediately. We asked one member of staff how they notified the maintenance man if there was an issue to be addressed. They told us they put this in the communications book but never knew if actions had been completed or when they would be done.

We found some parts of the kitchen had not been cleaned well, and that the fridges and freezers did not have temperature monitors. Meat and dairy were being stored in the one of the freezers and one fridge was not working effectively. We saw that temperatures were monitored daily but when we asked to see the temperature probes we found one not to be working correctly.

The heating of the home was inconsistent and had not been monitored. The temperature in the basement was 27 degrees centigrade whereas the temperature in the attic was 16 degrees centigrade and the back stairs corridor was only 8 degrees centigrade. A number of radiators were not working. We found in one bedroom the temperature of the water was 48 degrees centigrade which was too high. A number of bedside lights were not accessible or did not have an electrical point; we found an extension lead in use in one attic bedroom that stretched across the floor making it a trip hazard. When we returned on 05 February 2016, there were still issues with inconsistent temperatures in people's rooms. On further investigation, the main thermostat had been turned down which turned off the heating in some rooms. The registered manager told us they would put a system in place to ensure this could not be altered to ensure a consistent temperature in the home.

We found several new chairs had been purchased for the communal lounge but two of these were not suitable for people with a physical disability. They were large leather recliner chairs, which rocked when you transferred in and out of them increasing the risk of fall and injury. When we discussed this with a carer, they told us these new chairs were difficult for people to transfer in and out of safely. The registered manager told us the people living there had chosen these chairs. We asked the registered manager how they kept abreast of new equipment suitable for use in the care home setting. They told us they took advice from the therapy team's Occupational Therapists if it was around moving and handling equipment and they told us they had purchased the stand aid for a person following this advice. They told us they would always purchase any equipment recommended for a person living there. However, we found there was a general lack of awareness of the range of up to date equipment and how this could have a positive benefit to the independence of the people living there.

We found there to be a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Equipment and premises.

We saw that consent was consistently asked for by staff throughout the day. We also saw evidence in the care plans of written consent in relation to photographs. Although in one person's file this had not been

signed by the person and there was no reference as to the relationship of the person who signed the form. The registered manager told us everyone at the home had signed to agree to the use of the CCTV in communal areas. We did not see evidence of this at our inspection to confirm this was the case and we were not provided with this information following our inspection. As there were no capacity assessments and not all the people there had capacity to consent; the home were unable to evidence how they sought consent from people living there in relation to care, daily living activities and with regard to the recording of images by the CCTV. They had no record of who had a Lasting Power of Attorney to enable a person to consent on the behalf of another person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent.

The deputy manager told us they undertook supervision with staff three times a year. We saw evidence of one member of staff's recent supervision meeting which covered topics such as general appearance, time keeping, sickness, knowledge of policies and procedures, knowledge of own job description, documentation and what training the staff had undertaken. Comments included " Good knowledge of job description", "Is fully aware of documentation". The minutes of the supervision sessions lacked the detail to evidence that staff were supported to develop in their roles and that any gaps in knowledge and skills were identified through this process to ensure safe care delivery. Regular supervision of staff is essential to ensure that the people at the service are provided with the highest standard of care.

The deputy manager told us new staff completed the Care Certificate and we saw all other staff had completed the Common Induction Framework. The service used an external assessor for the Care Certificate and we saw evidence of the completed workbooks which demonstrated new staff were in the process of completing this to ensure they had the knowledge and skills to perform in their roles. One new member of staff told us the induction had been "Really good."

The deputy manager told us the service utilised in service and external training to ensure staff were skilled to perform in their roles. For example, half of the staff had undertaken training around infection control the week before our inspection with the rest of the staff to be trained the following week. They told us the registered manager undertook the training for food hygiene, fire safety training but we had not been provided with any evidence to determine whether the registered manager is competent to carry out this training. Staff told us that they had appraisal meetings with the registered manager throughout the year and felt supported and encouraged to undertake a variety additional training such as national vocational qualifications. Senior staff had appropriate health and social care national qualifications and the deputy manager was undertaking a National Vocational Qualification in management. We saw evidence that some staff had undertaken moving and handling refresher training in November 2015 as they had certificates in their files and some dates had been inputted onto the training matrix. This ongoing training ensures that people continue to be cared for by staff who have maintained their skills. However, the registered manager told us the training matrix had not been fully updated to reflect the staff training and showed some gaps. We asked the registered manager to send up an updated training matrix to detail which staff had undertaken training but this had not been provided in a reasonable time frame.

We spoke to visiting GP during our inspection to determine how people were supported to maintain good health and access healthcare services. They told us they were new to the service but had found the home good at communication and carrying out instructions. The deputy manager told us the district nursing services visited twice a day to administer insulin. They also told us an optician service visited the home regularly to undertake eye examinations and one person visited a dentist regularly. The deputy manager told us most people at the service wore dentures and when offered an appointment with the dentist, usually declined. We saw evidence in people's files that physiotherapy had been involved to improve people's mobility when required. This demonstrated the home was responding to people's needs to ensure on-going

healthcare support.

Good

Is the service caring?

Our findings

We asked the people who lived there whether they were supported by staff with care and compassion. One person said "I wouldn't change anything about here. They do alright by me. They treat me alright and with respect so I don't mind." Another said "I don't think they could do any better anywhere else." One person who chooses to stay in their room said "They keep coming to see if I want a drink. I'm not neglected." Another said "I'm happy here. It's the best place for me. If I was worried about something I'd talk to my daughter." And one person told us "I wouldn't change anything. It's perfect."

Staff were very kind and patient with people and were observed to be open and considerate in their approach. Where people were confused or needing reassurance staff spent time with them and offered comforting words and appropriate touch, such as hand holding. During the afternoon, one person who lived there became quite agitated in the lounge and was shouting at other people living there and staff. A member of staff sat with this person and spoke calmly , reassuring that everything was alright and trying to distract them from distressing thoughts and offering a cup of tea. The member of staff stayed with the person throughout and remained calm.

Staff we spoke with told us how they protected people's privacy and dignity. One member of staff told us personal care was always carried out in people's rooms. They told us they always undertook personal care in private and closed the doors and curtains. We found dignity curtains in both shared rooms to protect the privacy of the people who shared the room. However, we did see cream administered to one person in the communal area in full view of other people.

One person we spoke with told us they were supported to remain independent. They told us "I like to be independent. I do my own hair and give myself a strip wash. I don't want anyone else washing me." The deputy manager also described how they encouraged people to remain as independent as possible during activities of daily living such as washing and dressing and we saw evidence the home had assisted people to improve their mobility once they had taken up residency at the home.

Requires Improvement

Is the service responsive?

Our findings

The deputy manager told us they always assessed people before accepting them to the home and each admission was discussed with the registered manager to ensure the home could meet the needs of the person. There were designated staff responsible for named people as the home operated a key worker system, Care plans were written and updated by senior staff monthly. The deputy manager told us relatives rarely wanted to be involved with reviews and they have offered to do these over the phone with relatives. Relatives we spoke with during our inspection told us they were included in discussions about their relative's care plans, and they felt that they were kept informed about changes or incidents. Relatives were very positive about the care provided.
The deputy manager told us if anybody who lived there was reaching the end of their lives they would update the care plans on a weekly basis.

We examined four care files and found two care plans were generally well written and all had been evaluated monthly. We found there was limited information related to people's past lives and when we asked the key worker about the background of the people they were supporting they could not recall any meaningful information. We also noted that there were no life histories written for the people and most of the daily care records bore no relationship to the information contained in the care plans. Most care was delivered by a task allocation including a bathing schedule. In two care files for people who had rapidly changing needs we found incorrect information relating to past care needs in the file which if followed could lead to inappropriate care being provided. This was particularly evident around moving and handling needs, but we also found gaps in one person files around continence when it was evident this person had the need for a continence care plan.

We found most of the bedrooms were personalised and people were encouraged to bring in items from home. People told us they were able to exercise choice during the day in how they wanted to be supported and they told us they could get up and go to bed when they wanted. People were offered a choice from a menu selection and we observed the deputy manager asking people in the morning what they would like to eat at lunchtime from a range of options on the menu. This showed us staff were aware of the importance of ensuring people had choice and control over this aspect of their lives.

We also saw that there were entries in care records detailing visits and involvement with care professionals such as general practitioners and district nurses. We met one GP who was visiting on the day of our inspection who told us that although they were new to the practice they had visited the home on several occasions. They found staff to be knowledgeable, able to follow instructions and good communicators with the practice.

During our inspection we asked people whether they were supported to undertake meaningful activities during the day. One person said "I just mostly watch what's on telly. I'm not really bothered. It's just what comes on. Or I watch the goldfish or look out of the window." Another person said "I'm idle all day. There isn't any occupation I've been able to find here so far. It's an idle existence. There's very little happens. I feel I'm becoming institutionalised. I've no problems with anyone. We all get along." Another person said "They

do my nails (which were clean, manicured and polished). Yes I just sit here and watch the telly. It's got a nice big screen. It's my home." Other comments included "I'm quite happy. Sometimes we go out to the top where there's a lovely view, when it's nice weather." Another said "They don't come to sit and chat. They're busy with their lives. I'm not bothered. I've had my time. I'm content enough. I'll be going soon." "I don't do anything all day. I don't get bored. I like to just rest." One person who lived there said "I would like more outings into the open air. Even if it's chilly you can soon get warmed up."

In the morning of our inspection we saw care staff involved people living there with a game of chair skittles and a morning quiz. There was an activities plan in place which highlighted a morning and afternoon activity and the deputy manager told us they utilised the service of external entertainers, they had a hairdresser who came in once a week and they have someone to run an exercise class once a fortnight they told us staff make cards, bake cakes and do jigsaws with people .The deputy manager also told us one person was supported to use a tablet computer to "FaceTime" their relation who lived away. However, we found a lack of records in people's daily logs as to who had undertaken activities and therefore the registered provider did not have the evidence to support that all the people living there including the person cared for in bed, were involved in meaningful occupation throughout the day. We recommend the registered manager consider utilising nationally recognised guidance on ensuring wellbeing through activity in care homes to ensure all the people living there were supported to have meaningful occupation throughout their day.

The deputy manager told us there had been no complaints about the service in the past two years. They told us there was a procedure to follow if there was a complaint but they only received positive feedback from families and professionals involved with the service. Staff told us they had not dealt with any complaints but they knew how to report any concerns to the deputy manager.

We saw a complaints form in the manager's office and we were told when staff had supervision they were asked if they had any concerns related to either staff or people who lived at the home. We saw no evidence that information on how to complain was readily available to the people who lived at the home or how people were informed of their rights in relation to this aspect of the service. On discussions with the registered manager following our inspection, they told us of an incident where a person who lived there had complained they had not been given their medicines and another person had complained they had not been adequately assisted with personal care. Therefore, there had been complaints about the service, but there was no evidence these had been recorded or how these concerns had been effectively dealt with. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post. They had been registered since 2012 and had owned the home for 16 years. However, they had a limited on site presence at the home and were in full time employment elsewhere. Day to day running of the home was undertaken by a deputy manager who was present during our inspection but did not have access to audit and quality assurance systems. The deputy manager did not have access to a computer, printer or a photocopier and much of the information relating to the management of the home was on the registered manager's computer which was not on site. This meant we were not able to evidence management and quality audit assurance systems had been effective in identifying and addressing problems. The deputy manager told us the registered manager undertook the environmental and quality audits and the deputy manager undertook a weekly medicines audit, health and safety check, and the fire audits. We found examples where audits actions had been ticked as completed when they had not been completed. For example, we found beds did not have mattress covers on although daily audit showed these had been checked. In addition the deputy manager had ticked they had checked the fire doors were ok when the fire officer reported one door was not secured its hinges. There was no evidence that quality assurance systems were effectively used to drive continuous improvement and actions were often a reaction to inspection findings from the fire officers, the infection control and CQC. When issues were pointed out the registered manager agreed to action immediately, but their own systems did not recognise the need to improve.

As the registered manager was not present on a daily basis, they were not able to keep under review the day to day culture in the service, and there was no clear vision for the service amongst the staff we spoke with. We saw no evidence at the home as to when the registered manager had been present and they were not on the rota nor did they sign in when they visited. This meant that although the registered manager role is to be in day to day charge of the delivery of the regulated activities, there was no evidence to support this was the case. When this was discussed with the registered manager, they told us they could view what was going on in the home through the CCTV and they could be telephoned by the staff if required. The deputy manager told us they had a weekly meeting with the registered manager but could not provide any evidence on the day to support actions taken from issues discussed. We asked the registered manager and deputy manager how they kept up to date with best practice. Neither was able to advise us of any recent national guidance or how they implemented these to ensure standards at the home followed best practice guidelines. The registered manager had not yet undertaken an audit of the service against the fundamental standards. They did tell us they highlighted articles in periodicals for staff to read and these were left on site for staff and they also discussed these in team meetings. However, we saw no evidence to the effectiveness of this as a means of keeping up to date with best practice and none of the staff we interviewed advised us this is how they kept up to date.

There was evidence of good teamwork amongst the individual staff who reported high morale and said they enjoyed working in the home. One member of staff told us "I do enjoy working here. The staff are friendly and always happy to help. The residents are lovely". They also told us the deputy manager and the senior staff were supportive although when asked how often they had met the registered manager, they told us once since Christmas, whilst they had been on duty and that was to undertake their appraisal.

We were told by the registered manager that they held meetings with the residents and were in constant contact with relatives by email or telephone and because the registered manager had lived at the home for several years, the people and their families were like their own relative. We saw evidence of the latest survey which had mostly positive comments but we did see a comment suggesting more activities were provided. The deputy manager told us the actions they had undertaken to improve activities including use of the Access Bus on a Friday to access the community although we did not see the evidence to support this had happened.

Throughout our inspection we found maintenance issues requiring urgent attention. For example, we found roof windows in the attic rooms opened wide enough to egress and had no restrictors. We were told the maintenance person had removed these to fit blinds. We were also told the maintenance person was to fit window restrictors to the upstairs windows which had been highlighted as urgent following a recent fire inspection, but even though the fire officer had raised a safety concern about an open sash window in one upstairs bedroom, this was still wide open during our inspection and there was no restrictor fitted. When we mentioned this to the registered manager they told us the room was unoccupied. However, the door was not locked and any person using the service or staff member could have gone into the room and tripped and fallen out of the window. The registered manager told us the restrictors had been fitted shortly after our inspection but on our revisit on 4 February 2016 we found other windows which did not have window restrictors. The registered manager and deputy manager had not picked this up as there had not been an audit of the windows in the building. They had only actioned the windows we had highlighted as not safe. This demonstrated the service was not proactively managing risk.

We also found essential equipment not working at the home included the tumble dryer, the dishwasher, the computer, the printer, and the seated weighing scales. There was no system in place to ensure these were replaced. Consequently numerous significant problems related to the environment, repairs, purchasing of equipment remained unresolved and staff were not aware of when broken equipment could be expected to be repaired. The maintenance book was not on site and had been taken away by the maintenance person, so there was no evidence on site what had been reported, by whom and what action had been taken. When we did see the maintenance book on our inspection on 04 February 2016 we found there had been no entry in this from 13 September 2014 until after our inspection of 21 January 2016.

We were told by the deputy manager, there had been a staff meeting on 20 May 2015 and in September 2015 but the minutes of the meeting were not held on site and therefore we were unable to verify these meetings had taken place or the content of the meeting. We were sent the agenda of a team held in October 2015 meeting following our inspection but the information did not contain information on who attended the meeting or whether matters from the previous meeting were discussed and actioned nor the content of the team meeting. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. There was also no evidence that feedback was being monitored or analysed for trends or concerns which may require further action.

We found two of the four care files reviewed contained information which was incorrect around people's care needs and although these were reviewed monthly, the information was still incorrect. This demonstrated there was no systematic approach to auditing people's care records. We raised this with the registered manager who told us they would look into this immediately.

The registered provider had not notified CQC following an incident which resulted in a fractured femur and when asked the deputy manager told us they did not know they should notify us. When we asked the registered manger why we had not been notified they told us it was at a time they were abroad and

unavailable. They told us they would normally undertake this task and the deputy manager would not undertake notifications. This demonstrated a lack of delegated responsibility to ensure essential responsibilities were met in the absence of the registered manager. In addition, we asked how the service implemented Medical Device Alerts and in particular how they had implemented a 2015 in relation to the safe use of lap belts on equipment such as stair lifts, wheelchairs and bath lifts. The registered manager was unaware of this alert and told us this was issued at the time when they were unavailable. They told us they usually alerted one of the seniors to action. There was no evidence on site, this had been actioned and no system in place to ensure an adequate and robust process for implementing these alerts.

This evidence demonstrated the registered provider had failed to effectively assess and monitor the quality of the service provided to people and was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not provided with lawful consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not always recognised abuse to enable them to effectively minimise the risks to the people living there.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had not recognised concerns raised as complaints and therefore had not resolved these effectively or learnt from this experience.

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 The registered provider had not assessed the proper and safe management of medicines or ensured there were sufficient quantities to meet the needs of the people living there. The registered provider had not assessed the risks to people's health and safety and had not taken all reasonable steps to ensure the health and safety of people using their services by appropriately managing the risks

The enforcement action we took:

Warning notice to be complied with by 21 October 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises had not been maintained to a satisfactory standard and people's safety had not been maximised in the environment.

The enforcement action we took:

Warning notice to be complied with by 21 October 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no effective leadership at the service and the quality of the service provided had not been effectively monitored.

The enforcement action we took:

Warning notice to be complied with by 21 October 2016