

Mrs Dahiya







Sailaway Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate	
Is the service safe?	Inadequate	
Is the service effective?	Inadequate	
Is the service caring?	Good	
Is the service responsive?	Inadequate	
Is the service well-led?	Inadequate	

Overall summary

This inspection took place on 22 and 23 October 2014 and was unannounced. The service provides accommodation for up to 18 people, including people living with dementia. There were 11 people living at the service when we visited. The service is owned by the registered provider who also acts as the manager.

We found people's safety was being compromised in a number of areas. Infection control guidance had not been

followed in relation to the environment and staff practices. Therefore, people were not protected from the risk of cross infection. Incidents of potential abuse were not reported to the local safeguarding authority for investigation. The risks of people falling were not managed effectively as care plans did not contain enough information about measures staff should take to protect people. This put people's health and safety at risk.

Summary of findings

Parts of the building were not safe. An area where building work was taking place was not fenced off, the ceiling of one of the bathrooms was at risk of collapsing and the garden was not secure, meaning people were at risk of harm from fast moving traffic on a nearby road. The provider was not aware of guidance about creating environments that were dementia-friendly. Consequently, the design and decoration of the building did not meet the needs of people living with dementia or those with poor mobility.

Recruitment procedures were not adequate as suitable checks of references and previous employment details of some staff members had not been made. Staff told us they felt supported in their role, but we found they did not receive appropriate support through one to one sessions of supervision and appraisals.

Care plans did not contain enough information about people's nutritional needs and the support people needed to eat and drink. People's weight was not monitored effectively to ensure their nutritional needs were being met.

People were satisfied with the care and support they received. However, we found care planning was not adequate to allow staff to deliver care and support in a personalised way. People's continence was not managed effectively and family members told us there was a lack of mental stimulation for people.

Where people lacked the mental capacity to make decisions, the service did not follow the principles of the Mental Capacity Act 2005. Mental capacity assessments were not conducted and the provider could not show that decisions had been made in the people's best interests.

The systems for monitoring the quality of service provided were not effective as they had not picked up the concerns we identified.

Arrangements for covering short term staff absence were not robust and some relatives told us more staff were needed. However, staff felt there were enough of them to meet people's needs and we observed people being attended to promptly.

People were treated with kindness and compassion by staff who were warm in their approach, knew them well and understood their needs. Appropriate policies were in place to ensure people's privacy and dignity were respected.

Medicines were managed safely. People and relatives told us healthcare advice was sought promptly when needed.

There was a complaints policy in place; however, one relative told us they didn't know how to make a complaint and another said they would be reluctant to complain.

Staff enjoyed working at the service and described the culture as "warm" and "homely". We observed positive interactions between the provider, staff and people and relatives told us they were made to feel welcome.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Following the inspection we spoke with staff from the local safeguarding authority to discuss some of the concerns we had identified.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe. The environment was not clean and hygienic. Guidance on the prevention and control of infections was not followed, clinical waste was not stored securely, protective equipment was not readily available and the risks of cross infection were not managed effectively. Infection control risks had not been identified and assessed.

Safeguarding policies in place, staff had received training in safeguarding adults and knew how to report abuse. However, incidents of potential abuse had not been reported to the local authority safeguarding team as required.

Care plans did not contain sufficient information for staff to know how to protect people effectively from the risk of falls. Areas of the building and its grounds were not safe or secure. Improvement to fire safety which had been identified in 2013 had not been implemented.

There were sufficient staff on the days of our inspection, although arrangements to cover absence were not robust. Appropriate arrangements were in place for the safe management of medicines.

Inadequate



Is the service effective?

The service was not effective. Care plans did not provide sufficient information to ensure people received appropriate meals, prepared in a consistent way, with appropriate support from staff.

People's ability to make valid decisions was not assessed. The principles of the Mental Capacity Act 2005 were not followed to ensure decisions made on behalf of people who lacked capacity were made in their best interests.

The design and decoration of the building did not meet the needs of people living with dementia or people with poor mobility.

The provider supported staff by working alongside them, but not all staff received one to one sessions of supervision or appraisal to support their personal and professional development.

Inadequate



Is the service caring?

The service was caring. People were treated with kindness and compassion by staff who knew them well.

Staff understood the needs of people living with dementia. They were able to engage with them well and provide reassurance when they became distressed or anxious.

People's privacy and dignity were respected and, in most cases, staff knocked before entering people's rooms. Confidential information was kept securely.

Good



Is the service responsive?

The service was not responsive to people's needs and there was a lack of mental stimulation for people.

Inadequate



Summary of findings

Care plans did not contain sufficient information to allow staff to deliver care and support in a personalised way and some care plans had not been fully completed.

People's continence was not managed effectively as staff did not know how to support people with complex needs and they had not sought specialist advice.

Staff involved people in the planning and delivery of their care where possible.

Is the service well-led?

The service was not well-led. The provider did not send us information we had requested before the inspection. Incidents and accidents where people had been harmed were not investigated to ensure learning was used to prevent further occurrences.

Quality assurance systems were not effective as they had not identified the concerns we found. Key areas, such as care plans, had not been audited.

Staff told us they enjoyed working at the service and felt supported and valued by the provider.

There was little evidence of best practice being shared and implemented at the service.

Inadequate



Sailaway 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 22 and 23 October 2014 and was unannounced. The inspection team consisted of an inspector and an expert by experience in dementia. 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 asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the

service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report. We reviewed information we already held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people using the service and five family members. We also spoke with the registered provider, the administrator and three care staff members. We looked at care plans and associated records for six people; staff duty records; four staff recruitment files; records of complaints, accidents and incidents; policies and procedures; and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

Relatives told us they had concerns about the cleanliness of the service. One said, "I'm not sure what to say about cleanliness here; there's definitely not always enough towels or soap so that's not suitable". Another relative said, "There should be hot running water in rooms". We found the environment was not clean and hygienic. There was no alcohol hand gel available in key areas, such as the entrance hall for visitors to decontaminate their hands. The two bathrooms, the shower room and the downstairs toilet were not clean. These were used to deliver personal care to people, but some did not contain personal protective equipment (PPE), such as disposable aprons and gloves, to protect staff and reduce the spread of infection. Hot water, liquid soap and paper towels were not always available for staff to wash their hands after delivering personal care. People were put at risk of cross infection as infection control guidance was not followed

People's personal items, such as toothbrushes, toothpaste and razors were left on sinks and shelves in shared bathrooms. They were accessible to other people, including people living with dementia. If they were used by other people, it would put them at risk of cross infection. Three bedrooms smelt strongly of urine. Staff told us this was because the people using them were incontinent and urine had soaked into the carpets. However, the carpet in one person's room had been replaced with vinyl floor covering which also smelt of urine. No records were available to show when and how these floor coverings had last been cleaned, although staff told us they were cleaned daily.

In the laundry room there was a build-up of dust and cobwebs to the side and rear of the washing machine. Staff told us the sink was used to soak soiled linen, so a dedicated hand washing sink was not available. The room was being used to store boxes of PPE and cleaned towels. There was no process in place to prevent clean items being contaminated by dirty items entering the laundry. Clinical waste was stored in three bins which were not all marked as clinical waste or locked. They were accessible to people and visitors and put them at risk of infection.

Staff told us they had received training in infection control, but we saw they did not follow infection control guidance. One staff member was seen to carry soiled laundry by holding it close to their chest while not wearing a

disposable apron of gloves; another staff member sneezed and touched their nose repeatedly while preparing food. The service did not employ a cleaner. All cleaning was done by care staff in between providing care for people.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. We found these measures had not been taken in relation to the environment and staff practices. The code of practice also requires providers to complete an annual statement detailing what policies and infection control risk assessments are in place, and any staff training or outbreaks of infection that have occurred. The provider had not completed these and their policy on infection control referred to out of date guidance. Consequently the provider could not demonstrate that the risks of people acquiring getting an infection had been identified and were being managed effectively.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not respond appropriately to incidents of potential abuse. Records showed one person had been physically abused by another person using the service. Four other people had been injured as a result of falling. A relative of one of these people told us, "[The person] cut his hand and I can't get to the bottom of what happened as I've been told different stories". Incidents of abuse, or potential abuse, are required to be reported to the adult safeguarding team of the local authority, so they can be investigated and action taken to ensure appropriate safeguards are put in place to prevent further abuse. The provider had safeguarding policies in place; staff had received training in safeguarding adults and knew how to report abuse. However, none of the above incidents had been reported to the local authority safeguarding team as required.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The risks of people falling were not always managed effectively. One person's risk assessment had been reviewed in September 2014 and they had been identified as at high risk of falling. The risk assessment required staff to supervise the person when they were moving around,

Is the service safe?

but did not explain how they should do this or the level of supervision the person required. Records showed the person had fallen twice since then. This meant the risk assessment had not been effective and it had not been reviewed following these further falls so that additional safety measures could be considered. The care plan for another person, who had a history of falling, did not identify any measures that staff should take to prevent the person falling again. The provider had a “falls tracker” tool to monitor the number of falls and to help identify when a person started to fall more frequently, but this information had not led to any action to protect people. The provider had not taken appropriate steps to ensure people were protected against the risk of unsafe care.

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

Aspects of the building were not safe. People were put at risk from work that was being undertaken to create additional bedrooms to the side of the building. This area contained exposed wires, tools and building products. The provider’s risk assessment stated that this area should be fenced off, but it was not. It was accessible to people using the service, including those living with dementia, who could have been harmed. On the second day of our inspection we saw the area had been fenced off. The ceiling of the downstairs bathroom was bowed down and at risk of collapsing, following a water leak onto the flat roof above. Dust was falling from cracks between the ceiling tiles. The provider took the bathroom out of use during our inspection.

People could enter the front garden of the service via a door in the conservatory that was not locked during the day. The front garden was not fenced off and led to a main road, less than 100 meters away. Staff told us some people living with dementia would not be safe in the garden without staff supervision as they were unable to appreciate the potential dangers. Records showed one of these people had accessed the garden without staff supervision and had fallen. People were put at risk as the provider had not taken adequate precautions to prevent people accessing the main road.

Fire safety arrangements were not adequate. The fire and rescue service issued a notice to the service in September 2013 requiring it to make three improvements. One improvement was to install a device which would close the kitchen door automatically in the event of a fire, to replace

a wedge that was being used. The need for this was confirmed by the provider’s fire safety risk assessment. This improvement had not been completed and we saw a wedge was being used to keep the kitchen door open. The kitchen was an area of high fire risk and the failure to install the correct door closure device compromised people’s safety.

The above issues were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment procedures were not safe as appropriate checks were not always completed before staff were employed. For one staff member, records of their employment history were not available. References for another staff member had not been obtained. For a third staff member, the provider told us they had obtained a telephone reference, but had not made any record of this. The provider was, therefore, unable to confirm that staff had the necessary skills and experience for the role. Criminal records checks had been completed to confirm staff were of good character, together with checks to show they were entitled to work in the UK. The provider was not operating effective recruitment processes to ensure staff employed were fit to carry out their roles and did not pose risks to people.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received mixed views about whether there were sufficient staff to meet the needs of the 11 people living at the service. The provider told us two care staff were employed throughout the day, plus a cook. At night, two care staff were on duty, but one was allowed to sleep between 11:00 pm and 6:00 am and could be woken if needed. The provider told us they worked “most days” to provide additional support. Absence was covered by staff working additional hours. For example, on both days of our inspection the cook had reported sick, so another member of staff had been called in to do the cooking. On the night following the first day of our inspection, a member of staff had reported sick. The provider was unable to find a replacement, so worked the night shift themselves. They had worked the previous day and also worked the following day, a total of 30 hours without rest. This showed that arrangements to cover staff absence were not robust. Staff working excessive hours may not be fit to provide care safely.

Is the service safe?

A relative told us, “There should be an extra member of staff night and morning. Many residents here need two carers at a time to help them so it’s commonplace not to be able to find anybody and have to wait”. Another relative said, “I think the [response time to] call buttons could be improved. If they’re busy because there’s only two of them and they’re with someone it can take a while for a call to get answered”. A community nurse told us they sometimes had difficulty finding a free member of staff when they visited.

Staff told us that although some days were “busy”, there were “usually” enough staff to meet people’s needs effectively. During the two days of our inspection we observed people were attended to promptly and there were sufficient staff to support people appropriately.

Medicines were managed safely. We found there were appropriate arrangements in place for obtaining, storing, administering and disposal of medicines. Records showed people received their medicines as prescribed, from staff who had received training in the management of medicines.

Is the service effective?

Our findings

Choices of food were available for most meals, although records showed a choice of lunchtime meal was not always available. One person told us the food was “very repetitive” with little choice. Another person said, “I used to have a bacon sandwich every morning; its sets you up for the day; that’s what I do when I’m at home but not here”. People received regular drinks and were encouraged to drink well. One person told us “[The provider] is really hot on this”. When people’s drinks had gone cold, fresh ones were immediately offered. Cold drinks were readily available, together with a range of cups and beakers to suit people’s needs.

Care plans did not provide sufficient information about people’s nutritional needs. The care plan for one person showed they needed “some meals pureed” and needed “support to eat”, but did not specify which meals or what support they needed. Staff told us of another person who had fortified drinks each evening. However, this was not recorded in the person’s care plan and there were no records to confirm they had received them. The lack of information in care plans meant we could not be sure people always received appropriate meals, prepared in a consistent way, with appropriate support from all staff.

People’s weights were not monitored effectively. The care records for one person stated they had lost weight while being treated in hospital and “is now eating regular meals and hopefully putting on weight”. However, the person’s weight had not been monitored since they were discharged from hospital, in August 2014, so the provider was unable to confirm that the person was putting on weight. The care plan for another person required their weight to be monitored as they were at risk of losing weight, but they had not been weighed since May 2014. Consequently, these people were not protected against the risk of inadequate nutrition.

The above issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had been trained in the Mental Capacity Act 2005 (MCA). However, care records showed that MCA principles were not followed as people’s ability to make valid decisions was not assessed. The care plans for some people living with dementia contained no information

about their mental capacity and where this was provided, it was limited to a scorecard to indicate whether the person had any mental impairment. For example, one person’s score was eight, which indicated they had “periods of confusion and agitation”. The assessments did not relate to individual decisions or provide any information about how people’s scores affected their capacity to make decisions or the support they needed to help them make decisions. The care plan for another person said they were able to decide whether or not to take their medicines, but family members and a staff member told us the person had advanced dementia and was not able to make informed decisions about their medicines.

Staff had made some decisions on behalf of people, including decisions about the management of their medicines and the use of continence products. However, it was not clear how or why these decisions had been made for people, or whether people close to them had been consulted about the decision. With the exception of care being delivered by community nurses, which some people had signed their agreement to, there was no evidence to show that people had agreed to the care being delivered by staff at Sailaway Residential Home.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The majority of people living at Sailaway Residential Home had dementia. However, the provider and staff were not aware of guidance and advice issued by national bodies about creating environments that were dementia-friendly. Consequently, the design and decoration of the building did not meet the needs of people living with dementia. Signage was poor, confusing and inconsistent. There was little colour contrast to help people navigate around the building; and there were several large mirrors which can cause confusion or anxiety to people with dementia. One person’s room was stark as there was no shade on the ceiling light, no curtains or blinds on the window and no personal items or pictures. The person told us the lack of curtains meant the morning sun woke them early.

The building was not adapted to meet the needs of people with poor mobility. Some floor areas were uneven, which posed a trip hazard. There was a short, steep ramp between the dining room and one of the corridors which was too steep for people to navigate easily; and there was only one shared toilet available for people to use on the

Is the service effective?

ground floor (after the ground floor bathroom had been taken out of use). One person said, “the dining room is very tight for space and for getting about”. The conservatory was too cold for people to use in the mornings and the shower room was cold and uninviting. One person’s bedroom was noticeably cold; staff told us they turned on a portable heater in the evenings for the person, but the room would have been too cold for them to use during the day if they chose to spend time in there rather than the lounge.

The above issues were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us the provider ensured they got all the training they needed. One staff member said, “If you want training in something, [the provider] will always find a course for you”. Other staff praised the induction training and the support they were receiving to gain vocational qualifications. Records showed staff had been trained in all key areas of their work, including dementia awareness, and refresher training was on-going.

The provider supported staff in their work by working alongside them frequently. One staff member said they had also received formal one to one supervision and appraisals. However, staff records showed their most recent supervision was in June 2013 and their last appraisal had been in 2012. Another member of staff said they felt supported, but had not received formal supervision or appraisal since starting work at the service four years ago.

The provider told us they had conducted two appraisals in the past year, but confirmed that other members of staff had not received annual appraisals as required by the provider’s policy. There was no formal system in place to allow staff to discuss areas for development with the provider or for the provider to raise any areas of concern. The lack of effective systems meant people could not be sure that staff were appropriately supported to deliver care safely and to a suitable standard.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, we found that the provider understood when an application should be made. Staff had received training in DoLS. Therefore, the service was meeting the requirements of the Deprivation of Liberty Safeguards.

People and relatives told us healthcare advice was sought promptly when needed. A family member told us their relative had regular injections from the visiting nurse. The visits were confirmed by their care records and a community nurse, who told us the service contacted them appropriately for advice when needed. Other entries in care records showed people had frequent contact with doctors, chiropodists and specialists.

Is the service caring?

Our findings

We observed people being treated with kindness and compassion by staff who were affectionate and warm in their approach. Staff smiled as they went about their work, gently held people's hands and laughed with them. One person told us "They're nice and friendly here and make you feel like you're a human being". Another person said, "I've no complaints they always smile". Family members confirmed this. One said of the staff, "They're always welcoming and friendly" Another family members told us "They even did a little birthday party for me and I was so touched as [the staff member] made me a really elaborate birthday card that was so lovely".

Some people told us they were not able to make day to day choices, such as when they got up and where they spent their day, other people told us they could make these choices and care records confirmed they had been respected. A family member told us people had little choice about the music that was played in the lounge as staff put music on which they thought people would like. However, they said they were able to use the conservatory when they visited, where they were able to play music of their choice. They added "we sit in there for some normality together, so it is nice".

A person was seen knitting in the lounge with a care staff member who engaged them in relaxed conversation. Whilst doing so, another person began to cough and the staff member immediately went to their attention. Another person came in from the conservatory, commented on how hot it had become in there and was immediately offered a cold drink. When a television programme showed people

arguing and shouting at each other aggressively, a member of staff asked people if they were happy with the programme being aired or whether they would like to change channels. It was then changed to a programme of people's choosing.

Staff had completed training in dementia and understood the needs of people living with dementia. For example, they knelt down to engage with them at eye level. When people became anxious or confused staff remained calm. One person repeatedly became tearful about what they thought was going to happen later in the day and staff showed patience by explaining what was happening, in a number of different ways, until the person understood and became more relaxed. With other people, they took time to gently encourage them to accept help when they were reluctant to accept support to keep them safe while moving around. We saw a bag in the hall, which staff told us was for a person who believed they were going to go home. They said they were happy to enter into the person's reality and leave the bag in place, as it gave the person comfort.

The service had appropriate policies in place to ensure people's privacy and dignity were respected. Staff described how they did this in practice, for example by making sure doors were closed when people received personal care. Where people were able to attend to their own personal care, staff waited outside the bathroom until or in case the person asked for support. On all but two occasions, we observed staff knocked and waited for people to answer before entering their rooms. We saw confidential information, such as care records, was kept securely and could not be accessed by people who were not authorised to see it.

Is the service responsive?

Our findings

People took part in a range of activities. These included general games, quizzes and specific activities relevant to people, such as board games they enjoyed or painting. However, people were not given a choice about when these were arranged, which staff told us normally took place at set times in the afternoon. The relative of one person said, “My main concern is a lack of stimulation. [The person] was taken out once and was a different person, but it only happened once”. Another relative said, “[The person] doesn’t like the games they do so there’s not a lot going on”. The provider told us they took people on trips to local attractions in the summer and usually organised a summer event for people and families to attend; however, they said this had not happened this year as they had had to take time off work for personal reasons.

People were satisfied with the care and support they received. One person said, “The staff are excellent, the care is excellent”. Another told us “Everything is OK”. However, we found care plans did not contain adequate information to allow staff to deliver care and support in a personalised way. Four of the five care plans we viewed were based on a scorecard system that used ‘tick boxes’ to assess people’s needs in a range of areas, together with a short summary of people’s main needs. The areas included people’s continence, mobility, behaviour and mental health but there was no detailed information about how staff should meet people’s identified needs. For example, comments in one care plan said the person “can be very stubborn and will refuse help”, but did not state what this behaviour related to or how staff should support or encourage the person to receive the help they needed. Another person’s care plan described the help they needed with personal care, but did not describe how and when the person preferred to receive such care. Other care plans had not been fully completed. For example, the care plan for one person detailed how they liked to be supported when receiving personal care, but contained no information about the person’s mobility and mental health needs. The lack of detailed care plans showed staff had not taken into account people’s individual needs when planning their care.

Care plans had been signed by staff to show they had been reviewed each month and staff were clear about how they continually reviewed and assessed the needs of a person

whose condition varied from day to day. However, where updates had shown that people’s needs had changed, there was no information about how staff should meet those new needs. For example, one review described how the person “sometimes gets aggressive at night times if they don’t want to go to bed” but did not provide any guidance for staff about how to support the person when this happened.

People’s continence was not managed effectively. Staff told us about two people who were incontinent, whose rooms smelt strongly of urine. The care plan for one of these people was not up to date. They had not been assessed by a specialist and staff said they did not know how to manage the person’s needs effectively. A relative of this person said, “I think [the person] needs more qualified care”. The care plan for another person showed they needed to be prompted to use the toilet, but did not detail how and when staff should prompt the person or whether the person used any products to support their continence. The care plan for a third person explained the continence support the person needed at night, but not the support they needed during the day.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a complaints policy, which was displayed in the foyer, but no complaints had been recorded in the complaints log. The provider told us how they dealt with a complaint relating to the availability of hot water in a person’s room and said they had resolved it with the family concerned. However, the complaint had not been recorded and the issue had not been resolved effectively as we found hot water was still not readily available in the person’s room. The relative of one person said, “[The provider] is very bubbly and very nice but doesn’t like comments and takes everything as a complaint or a criticism”. They said this made them unwilling to complain. Another relative told us they did not know how to make a complaint. This meant there was a risk people or their relatives may be reluctant to make comments which could be used to improve the lives of people using the service.

The provider conducted annual surveys to obtain feedback from people and their relatives. We looked at the last survey, conducted in May 2014 and saw two survey questionnaires had been completed by relatives and none by people using the service. The responses were positive.

Is the service responsive?

The provider told us they used to hold residents' meetings, but people were no longer able to contribute to these due to their dementias. Instead, they said they talked to people informally, on a daily basis, to seek feedback about the care they received. We observed this happening during our inspection. The provider told us they had made changes to the menu following feedback from people.

Staff involved people in their care and support on a day to day basis. For example, when people went to the bathroom, staff checked whether people wanted them to go into the room with them or just wait outside. At lunchtime, before cutting up a person's meal, staff asked if the person wanted support to do this. This helped promote people's independence. Family members told us they were kept up to date with any changes in their relative's health.

Is the service well-led?

Our findings

The service was owned by the registered provider who also acted as the manager. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). They did not return a PIR and told us this was because it was sent to the registered provider rather than the administrator and there was a break down in communication. This meant we were not able to use the information when planning our inspection.

A person had fallen in the lounge at the beginning of 2014 and died as a result, following admission to hospital. The service had not investigated or analysed the incident or made any changes to the way it operated. There was no system in place to ensure that learning from incidents, such as this, was used to prevent further harm to people. Internal procedures were in place for the reporting of accidents and incidents and we saw a range of incidents had been recorded, including a safeguarding referral relating to a person who missed some injections following their release from hospital. This incident had been investigated and resolved.

There was a lack of systems for monitoring the quality of service provided which meant the provider had not picked up the concerns we identified, such as those relating to: infection control, safeguarding, care planning, falls, the environment, recruitment, nutrition and mental capacity assessments. The service was small and the provider spent time working with staff on a daily basis, helping to deliver care and support. They said this allowed them to continually assess how staff were working. The provider had also conducted an audit of medicines, in October 2014, which confirmed that medicines were being managed safely. They told us of plans to undertake audits of infection control, care plans and people's rooms but these had not been completed.

The above issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff enjoyed working at the service and felt supported and valued by the provider. They described the culture of the service as “warm” and “homely” and said they and the provider worked hard to create a “family atmosphere”. There was little turn-over of staff, which helped the provider build a close team. We observed positive interactions between the provider, staff and people. A relative confirmed this, saying “There’s a good atmosphere; you can tell [the provider] gets on with her staff”. Relatives told us visitors were encouraged and made to feel welcome. The service had few links with the neighbouring community, apart from the local church, whose minister visited on the second day of our inspection to discuss arrangements for a Christmas service.

People and staff knew the provider well. When the provider was in their office, their door was always open and we observed people and staff regularly visiting the office for advice or a chat. The provider told us they held staff meetings every six months, although the minutes from these meetings were not available. The provider did not hold regular meetings with staff and people, so the opportunities for staff and people to feedback on the quality of service provided was missed.

We found little evidence of best practice being shared and implemented at the service, although the provider told us they had experimented in the use of “key workers” for each person. This is a system that gives each person a nominated member of staff who takes a particular interest in their care and support and acts as a point of contact for the family. The provider told us they stopped using key workers as they preferred staff to “look after everyone, not just their key people”.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

The registered person had not ensured that service users were protected from the risks of inadequate nutrition and dehydration. Regulation 14(1)(a) and 14(1)(c).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

The registered person had not ensured that service users were protected from the risks associated with unsafe or unsuitable premises. Regulation 15(1)(a), 15(1)(b), 15(c)(i).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

The registered person had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided. Regulation 18.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

The registered person did not operate effective recruitment procedures in order to ensure that people employed for the purposes of carrying on a regulated

This section is primarily information for the provider

Action we have told the provider to take

activity were of good character, and had the necessary skills and experience. The registered person did not ensure that information specified in Schedule 3 was available. Regulation 21(a)(i), 21(a)(ii) and 21(b).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

The registered person did not have suitable arrangements in place in order to ensure persons employed were appropriately supported by receiving appropriate professional development, supervision and appraisal. Regulation 23(1)(a).

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs. Regulation 9(1)(b)(i), 9(1)(b)(ii) and 9(1)(b)(iii).

The enforcement action we took:

Warning Notice issued - to be met by 1 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected service users against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services provided and make changes relating to the analysis of incidents that resulted in harm to service users. Regulation 10(1)(a), 10(1)(b), 10(2)(c)(i) and 10(3).

The enforcement action we took:

<Insert description of action together with any timescales as relevant>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person had not ensured that service users and others were protected against the risks of infection. Regulation 12(1)(a),(b)&(c), 12(2)(a) and 12(2)(c)(i)&(ii).

The enforcement action we took:

<Insert description of action together with any timescales as relevant>