Heathcare Ltd

Heath House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 28 and 29 November 2016.

Heath House Care Home is a service that provides accommodation, personal care for up to 25 people. The home consists of a ground floor and first floor in a converted Victorian building. There were some people living with dementia. During the inspection visit, there were 17 people living in the home.

There was a registered manager employed at the home. 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 and associated Regulations about how the home is run.

At the last inspection on 12 October 2015, we asked the provider to take action to make improvements in respect of the quality of care that was provided to people. At this inspection, we found that the necessary improvements had not all been made. People's medicines were still not being managed safely and staff had not assessed and managed risks to people's safety effectively. The systems in place to assess, monitor and reduce the risk of people receiving poor care were not always effective. You can see what action we have told the provider to take at the back of our report.

Risks to people's individual health and safety had not always been assessed, and there was no guidance for staff to mitigate these risks. This included risks to people of not eating enough, and risks of developing a pressure area. Risks associated with people's personal activities where necessary, had not always been assessed and mitigated.

You can see what action we have told the provider to take on the back of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Risks associated with people's living environment had not been effectively assessed and lessened. There were also aspects of people's living environment that were unclean, presenting a risk of infection spread. There were problems with people's living environment which compromised their privacy and dignity.

Staff members did not have guidance about people who were at risk of not eating and drinking enough. The home did not always provide staff with adequate guidance in respect of thickening people's drinks, and storing thickener safely.

Medicines were stored and administered safely, however there were risks associated with 'as required' (PRN) medicines not having clear protocols in place for staff to follow. Staff did not always follow recommendations given by health professionals, and they did not always ensure that people were referred to them when they needed.

There were not always staff available to support people when they needed it and this resulted in falls and delays to people receiving assistance with personal care.

People did not receive a daily choice of meals. They were provided with enough to eat and they had drinks available throughout the day to them.

People did not always receive individualised care based on their own needs and preferences. Care plans did not contain adequate current guidance for staff.

People were supported to engage in activities with staff although these were not always available for people in their rooms or for whom group activities were not suitable.

Most staff were kind and caring. However, some staff demonstrated poor practice, which resulted in some people not being treated with dignity and respect.

The systems in place for monitoring and assessing the quality of the service did not always pick up problems and therefore had not acted to improve the quality of the care provided.

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 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.

Risks associated with people's safety and health, as well as their activities and environment, had not always been assessed and managed.

There were not always staff available when people needed them.

Most medicines were stored and administered safely, however improvements were required regarding the security of some medicines such as thickener and creams.

Some areas of the home were unclean and presented an infection risk.

Staff were trained in safeguarding and knew how to report poor practice.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people were at risk of not eating or drinking enough, there was not always guidance for staff to support people in respect of this. Most people had access to drinks.

People were not always supported to access the appropriate healthcare they needed in a timely way and staff did not always follow healthcare recommendations.

Staff received training relevant to their roles. Staff sought consent from people before delivering care and people's mental capacity was assessed appropriately.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff practices, and aspects of the home's environment, did not always respect people's privacy and dignity.

People had visitors when they wanted, and staff were kind to people. Where appropriate, relatives were kept informed of any changes or concerns regarding people's care and wellbeing.

Is the service responsive?

Requires Improvement

The service was not adequately responsive.

There were not detailed care records in respect of people's personal, individual requirements and therefore people did not always receive individualised care.

People knew how to complain and people and relatives said they would complain if they needed to.

Is the service well-led?

Inadequate

The service was not well-led.

The systems in place for assessing, monitoring and improving the service were not always effective.

There was not always good leadership in place with appropriate support for staff.

Heath House

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.

It was carried out on the 28 and 29 November by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This was an unannounced inspection.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also 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.

During the inspection visit we spoke with nine people living at the home and two visiting relatives. We also spoke with two care staff, including a senior carer, the deputy manager and the registered manager as well as the cook and a visiting healthcare professional. We observed how care and support was provided to people.

We looked at two people's care records in detail and sections within another three people's care records, and all medicine administration records. We also looked at accidents records, and records relating to the safety and maintenance of the home as well as staff training.

Inadequate

Is the service safe?

Our findings

During our inspection in October 2015, we found that people's medicines were not always managed safely. This resulted in a breach of regulation 12 of the Health and Social Care Act 2014. People's creams were not being stored securely and safely. The registered manager sent us a plan detailing what action they were going to take, which they said would be in place by December 2015. On 28 and 29 November we found that some of their specified actions had been taken. However, the provider was still in breach of this regulation, as we found further concerns in relation to the management of risks to people.

During our visit we found that prescribed items were not always stored safely. For example, we saw that thickener for drinks had been left out in people's room as well as in communal areas. This posed a risk to people who may be living with dementia, of ingesting this and choking. We advised the registered manager of this who then ensured that this was put away.

The registered manager had not adequately assessed risks to people's safety. Prior to our visit the boiler had broken down, which left the home without central heating. Hot water was available to most areas of the home through the immersion heater. The registered manager had installed portable oil and electric heaters within communal areas and people's rooms. Risk assessments had not been carried out for the use of the portable heaters. We found that there were two rooms that felt cold, and there were no thermometers available so that staff could be assured that people's rooms were warm enough.

We found that further risk assessments associated with people's health had not always been carried out. People's care records did not contain information about how the risks of developing pressure ulcers should be managed. For example, one person who was cared for in bed was deemed to be at high risk of developing a pressure ulcer. They did not have a repositioning plan in place and staff had not recorded any time when they had helped the person to reposition. We spoke with two members of care staff and the registered manager about the person, who gave inconsistent information about how they supported this person to reposition.

Risks to people were not always mitigated and staff did not always follow professional recommendations to prevent pressure ulcers. An example of this was that one person had been prescribed a pressure relieving boot to minimise risks associated with developing a pressure ulcer on their heel. We saw that staff had written in the care plan that the healthcare professional had advised that the person wear it all the time. We saw that the boot was in the person's room, and spoke to them about it. They said they never wore it. There was no record of the person having worn it. We confirmed this with the deputy manager, who went on to say that the person wore it when they were on bed rest but at times refused it, none of which was recorded. The person told us when we spoke with them that they were still having trouble with a pressure area on their heel. We spoke to the community nursing team, who confirmed that they had prescribed the pressure relieving boot in April 2016. They said that the staff were not able to give them a reason why it had not been worn. The evidence we gathered demonstrated that people were not adequately protected from the risk of developing pressure ulcers.

There were no risk assessments in place that covered various activities. For example, we saw that one person living in the home smoked outside. The registered manager told us they could use the door near their room to go outside and smoke whenever they liked. There were no risk assessments in place concerning this activity and any risks this may have posed to the person or others in the home. The registered manager confirmed that there was no risk assessment in place. We found on the second day of our inspection that they had done a further risk assessment which covered some risks associated with the person's safety. However, we found that this did not identify any risks or create any guidance for staff on how best to mitigate risks to the person or others, so therefore it was not adequate.

An incident also occurred around the time of our visit which resulted in a referral to safeguarding. This was around a person, who was living with dementia, leaving the home, who was later found by police. This event had put this person at serious risk of harm.

People were not always able to ask for assistance from staff; one person we visited in their room had been left with no access to a call bell or means to ask for help. The person was unable to walk and access their call bell which was on the other side of the room. Another person also confirmed they did not always have access to a call bell when in their room. They told us, "I have had several falls, a serious one a few weeks ago…Unfortunately I didn't have my cord as it won't go all around the room. I waited two hours." We saw from records that this person was deemed to be at high risk of falls due to being unsteady on their feet. This demonstrated to us that people's safety was compromised because they could not always call staff when they needed them.

We saw that some areas of the home were visibly dirty which presented a risk of infection. The morning we arrived there was a strong malodour in one area of the home and two dirty toilets. We returned two hours later to check on the toilets, one of which had been cleaned. We asked a member of staff to clean another one as we saw that someone was about to use it. On the second day of our inspection, we saw areas of one person's room that were visibly soiled and there were several dirty, unvacuumed carpets. A member of housekeeping staff told us they had just finished cleaning upstairs on the first day of our inspection, when we found that the carpets were still dirty. There was a cleaning schedule in place which was regularly ticked off, and it had not been identified that the home was still dirty in some areas following the cleaning.

These concerns constituted a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were concerned about the level and deployment of staff in the home. One person told us, "Nearly every day they are short of staff." This was reflected by everyone we spoke with. This impacted people's safety; some people explained that they tried to walk unsupervised when staff were not available to support them to go to the toilet. One person said, "I can't get up from the chair and walk. I have had so many falls, my legs just give." Another person also told us they found it very embarrassing and uncomfortable. It was also confirmed by one relative that the home was, "Short-staffed."

A visiting healthcare professional explained that they also had concerns about staffing levels. They said they had arrived once and found that the person they were visiting had not received personal care since the night before. Their previous evening meal was still on their table next to them and the person was in a wet and soiled bed. One of the members of staff we spoke with said that they did not feel there were enough staff and that people had to wait for assistance. Another said, "We need more staff, they're (staff) stressed and tired." One member of staff we spoke with said that they felt they had enough staff to meet people's needs, but not always to spend extra time doing activities with people. We also saw that a recent complaint received by the home raised concerns associated with staff not being available. The complaint was received

in September 2016 relating to care provided during the summer of 2016. They said that staff were on breaks at the same time and not available to their family member on several occasions when they had required assistance. This provided evidence to us that there were not enough staff deployed appropriately to be available to people across the home.

We asked the registered manager how they ascertained how many staff they required according to people's needs. They said they did not calculate people's needs and assess dependency levels in order to staff the home according to those needs.

We ascertained that there were not always staff effectively deployed to keep people safe.

These concerns constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Since our last inspection, the registered manager had arranged for lockable cabinets to be installed in everyone's room, so that they could keep their prescribed creams safely and securely. During this inspection we found that these were in place, however we did visit one person's room and found the lockable medicines cabinet had been left open. This still posed a risk that the creams inside could be used inappropriately.

We found that there were no protocols in place for the administration of 'as required' (PRN) medicines. This had also been identified during our visit in October 2015. This included for the use of pain killers and sedatives. There was no guidance in place for staff to advise what they should do prior to offering the medicine and when to administer it. The deputy manager was able to tell us when and how these would be prescribed and recorded, and we saw that these had not been given regularly. Another staff member was also able to tell us how they gave people PRN medicines, and this confirmed what the deputy manager said. The registered manager told us that they did not have individual protocols in relation to each person's PRN medicines. They agreed that they would put these in place. There was a risk that these could be used inappropriately by staff because there was no guidance in place. The PIR had said that these protocols were in place, and we found that this was not the case.

The medicines administration records (MARs) contained a front page which included a picture of the person for each record. Any allergies the person had to medicines were detailed on the top of each MAR sheet. There was no information available about how people preferred to take their medicines. This posed a risk that people may not always receive their medicines appropriately according to their own preferences.

When we looked at the individual MARs, we saw that staff had administered the medicines according to the prescriber's instructions, including higher risk medicines. Medicines were stored safely and securely, and within advised temperatures. The audit carried out by the deputy manager on the stock of medicines was effective and we found that medicines we checked tallied with the expected amount.

Some risks to people's safety had been adequately assessed and managed. For example, where people were at risk of falling out of bed, staff had completed assessments and there was equipment in place to manage this. Where one person sometimes presented behaviour that others may find challenging, staff had carried out risk assessments and actions had been taken following this to resolve any problems.

There were health and safety checks that were carried out on lifting equipment, emergency lighting and fire alarms to ensure that people's environment was safe to live in. Other checks included legionella and water testing.

One person told us, "Oh yes I feel safe." This was reflected by three further people we spoke with. Staff had received training in safeguarding and whistleblowing. They told us they felt confident to report abuse or poor practice. The deputy manager gave us an example of a recent investigation that had occurred at the home. They demonstrated that safeguarding practices were in place to contribute to keeping people safe.

Staff were recruited with procedures in place to keep people safe. This included ensuing staff had obtained a criminal record check and references before starting work. This meant that staff deemed suitable to work with people were employed in the home.

Requires Improvement

Is the service effective?

Our findings

It was not always clear from people's care records how they should be supported with eating and drinking. An example of this was that one person who was cared for in bed, received a pureed diet and thickened fluids. However, we saw on the two days of our visit that the person's thickened drink was made to different consistencies. When we looked at the box of thickener, the directions were 'use as directed.' There was not clear guidance immediately available for staff on exactly how much thickener the person required in their drinks. The person required drinks of a certain consistency and these were not always available to them.

People did not always have access to a drink. For example, one person was in their room with no access to their call bell. They had an empty cup in front of them and no jug of water. Therefore they did not have access to a drink. The person was not able to get themselves a drink and asked us for one when we visited them, which we promptly asked staff for. This meant that the person was not able to call for assistance if they needed any, and was not able to drink when they wanted.

Staff did not always ensure that systems were in place to support people to drink and eat enough. We found that for one person, they had been weighed in October 2015, and then again in May 2016. The person had lost a significant amount of weight in that time and were underweight and deemed to be at high risk of not eating and drinking enough. The registered manager told us that the person did not consent to being weighed and therefore they did not weigh them. There was no record of any other methods by which to assess this person's weight loss.

This person required full assistance from staff to eat and received a pureed diet. We saw that although staff recorded when the person ate and drank, they had not always documented when the person had refused. We saw that on one day, staff had written nothing down at breakfast time, for example they had not specified whether the person was offered anything, what it was, if the person refused or if they tried offering something different. This meant there was a risk that staff would not know when that person had last been offered something to eat. The staff we spoke with told us it was at times difficult to encourage the person to eat and drink. There was no specific guidance in place in the care records, guiding staff on how best to encourage the person and what to do when they refused. The registered manager told us that the person often refused food and drink, and that when they were concerned they called the GP.

The person had not been referred to a dietician or speech and language therapist. We asked the registered manager about this and they told us the person had been discharged from speech and language therapy so they did not need them any more. When we checked the records, we found that the person had been discharged in 2010. It had not been identified that this person's needs and circumstances had changed, therefore it had not been considered that they required another referral. This did not demonstrate that staff consulted the relevant health professionals regarding people's eating and drinking in a timely, appropriate manner. We found that there had been inadequate monitoring and action taken for this person to prevent them from becoming underweight.

The concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated

Activities) 2014.

We observed that drinks were available within the communal areas of the home. We saw that people in the lounge had a drink at all times and that staff regularly offered people hot drinks as well. We saw one person who we visited in their room had been left without access to fluids. Other people that we visited had a jug of water available which was within reach.

People had varied views of the meals they received. One person told us the food was, "Okay." Another described it as, "Alright." Another said their meal was cold and did not eat it. We saw that in a recent meeting for people living in the home people had requested certain foods, which the registered manager had obtained for them. On the second day, one person told us that they did not like that day's meal, and another said they would like more variety and they had not been given a choice. We asked if they had requested something else but they said they had not thought of that. People were given one main meal a day at lunch time, and sandwiches every day for tea. We asked the registered manager whether people were given a choice of what they wanted to eat each day. They told us that people were given a choice because if they did not like what was on offer the cook was happy to make them something else. We saw a menu list of the meals that were cooked each day for four weeks and saw that one main meal was offered at lunch time each day. This did not demonstrate that they were proactive in offering choices of well-balanced meals to people. Meals were served where people were sitting or in their rooms.

A person with dietary requirements told us that staff ensured they received food they could eat. The cook was able to tell us about people's dietary needs, such as someone being vegetarian, which we found were adhered to. The cook told us that all of the food was made on site in the kitchen, and they were able to tell us about certain people's preferences. We saw that fresh fruit was available for people in the lounge. We observed that staff asked what people wanted for breakfast, and people had a choice of cooked breakfast or a variety of cereals or toast. One person confirmed that they had a choice of sandwiches they liked for their evening meal.

One person told us, "My cough is very bad sometimes but then it goes away. I guess I could see a doctor but I don't want to make a fuss". Staff had not proactively asked this person whether they wanted to see a doctor and reassured them that it would not be any trouble. We found that where people had falls, they were not always referred to the falls team. People were supported to access healthcare such as a chiropodist or a doctor, however during our visit we found that staff did not always follow recommendations given by healthcare professionals. We found that for one person, staff had not followed recommendations from the community therapy team, and the district nursing team. We also saw that where it was needed, people had not always been referred to services such as speech and language therapy, continence team or to a dietician when they needed. This meant that people did not always access healthcare when they felt they should.

Staff received training in areas relevant to their role. This included first aid, supporting people to move and food hygiene. Following our visit the registered manager told us that twelve members of staff had received full practical first aid training. However, one member of staff said that the first aid training they had received had not included the practical application of administering first aid in an emergency. They said they had asked the registered manager about this and that they would organise for them to have this. One member of staff said that they had also received training in dementia care, which they said helped them to better understand the people they worked with. They told us this meant that they could communicate more effectively with people.

The staff we spoke with said they received supervision and that they could go to the deputy or registered manager to ask for advice when they needed. However, one person who was new to the service, said that

they had not received regular supervision since starting work in the home seven months ago. When we looked at their record we could see that they had received an appraisal where they had discussed their progress with a senior member of staff. This meant that although they had had an opportunity to raise any concerns or issues on one occasion, this had not been regular enough for the member of staff to feel well-supported. Other staff we spoke with said they received supervision and the registered manager had a timetable in place for the management team to carry them out with staff. Supervision is a meeting in which staff can receive feedback on their work, discuss their role and raise any concerns or requests for training.

There was an induction period for new staff where they received training and shadowed a more experienced member of staff until they felt confident to work alone. We could see from records that the registered manager had signed off their competencies in their appraisal in areas such as providing personal care to people, following their induction.

Staff were supported to undertake the Care Certificate, which is a national set of standards in care. However, the registered manager did say that some staff did not keep up with their work as they should and they had some trouble encouraging the staff to complete it. One new member of staff said that they did not always feel they had time to do it due to time constraints.

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 so that they can 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 home was working in line with the MCA.

During the inspection we observed staff asking for consent when delivering support to people. Staff were able to tell us about different people's capacity. Where people lacked capacity to leave the home safely of their own accord, the manager had applied for a DoLS authorisation. We could see that, whilst awaiting authorisation, decisions were made in the least restrictive way possible, and in the person's best interests.

Requires Improvement

Is the service caring?

Our findings

One person told us, "I call out if I want help. Sometimes they [staff] say 'we came to you an hour ago', I say I don't care, I can't time things." Another person said, "They haven't got time for you." This did not demonstrate that staff always had a caring and respectful approach to supporting people.

Staff demonstrated some poor practice concerning people's dignity. During our visit we heard staff refer to some people who required support with eating as, "Feeds." This did not respect people's dignity and individuality.

The environment that people lived in did not always respect their dignity and was not always suitable. For example, there were two people who had constantly leaking taps in their rooms and this had not been rectified, one of whom told us the taps had been leaking for a long time. Their visitor confirmed this, saying it was very annoying to hear the constant dripping. We also found that the only shower available leaked from the top, causing the pressure to be very low, and due to the shower being quite open, meant it was not inviting.

We also saw during our visit that the shower room did not lend any privacy if people had to be supervised by staff, but not fully assisted with showering. There was no privacy curtain staff could stand behind, and there was a large frosted window with no curtains or blind. One staff member said, "There's no privacy in there really."

When we arrived at the home we saw that there was a great deal of old equipment in the back car park, consisting of frames, commodes, boxes, armchairs and other items. . We asked the registered manager about this and they said it was there because they had to redecorate some areas of the home and get rid of some things. We also noted that in the outside courtyard area at the back of the home, there was an open pedal bin with a clinical waste bag in it which had been left outside.

We observed that when staff went into people's rooms, they respected their privacy by knocking on the door first. We also saw that people's records were kept confidential which contributed to their privacy. We observed that when staff asked people who were sitting in communal areas if they needed support with personal care, this was done discreetly.

People told us that staff were kind and caring. One person we spoke with said, "They are really nice people here, staff very caring and considerate and they work hard." Another said, "The staff are very caring." A relative we spoke with also confirmed this. One person told us how supportive staff had been when they had been through some unpleasant health problems. The staff were able to tell us about different people and demonstrated that they knew people well. We observed some positive, warm interaction between staff and people living at the home during our visit. For example, we saw two members of staff joking with one person who was laughing with them.

Staff explained to us how they gave people choices, for example when they supported people with personal

care, they ensured that people chose for themselves what they wanted to wear. This ensured that people were involved with their care with respect to dressing. One member of staff explained how they communicated with someone with speech problems and how this enabled them to try to give the person as much choice as possible with regards to their care. One person we spoke with said that staff respected their choice to have a specific gender of carer. Some people said that they were able to choose when they got up and went to bed, however others who required assistance from staff did not always have a choice.

A relative we spoke with told us that staff kept them updated if there were any concerns about their relative or any changes to their wellbeing or care needs. There were also meetings held for people in the home where they could share their views about the home and give feedback. We saw the minutes of the last meeting which demonstrated that the people who attended gave feedback on the home. The registered manager had responded to some feedback which people confirmed. For example, one person told us that the registered manager had got some extra food that they requested. People were supported to have visitors when they liked. Some people had decorated their rooms according to their wishes with personal items from ornaments, books, photos.

Requires Improvement

Is the service responsive?

Our findings

When we visited in October 2015 we found that the home did not always provide care that was based on people's individual requirements, and there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not receiving care that took into account their social and emotional needs. The provider sent us a plan detailing what actions they would take, to be in place by 30 November 2015. We found that some actions had been taken to ensure that people received some activities, however not enough action had been taken to ensure people received quality care based on their individual needs. The provider was still in breach of this regulation.

People did not always have their social needs met. Two people told us they were lonely living in the home, and another told us there was no entertainment for them. When we visited we did observe that many people were sitting in the same chair all day with very little stimulation. We looked at the log of activities and saw that although staff did some activities with people in the lounge, people who did not wish to participate in group activity or were in their rooms did not always have the opportunity for meaningful engagement. One member of staff did tell us, "When we're short-staffed we don't have that one to one time." They went on to give an example of one of the people who told us they were lonely, saying they did not always have time to give them company.

During our visit we saw that staff played catch with some people and engaged them in activities such as painting their nails. We saw that this gave people the opportunity to chat with staff and engage in conversation. Staff told us they did this most afternoons in the lounge, which meant that some people received the opportunity to engage in activity and interaction.

People did not always receive care according to their preferences. We found examples of this in that some people's care records specified that they enjoyed a bath. The records we looked at did not contain information about what times people preferred baths or showers. However, the registered manager told us that all of the people preferred a shower and nobody living in the home had baths. Another member of staff told us that people living in the home needed encouragement to have either baths or showers. We observed that the bath was used for storing commodes and other pieces of equipment. It was not clear from people's records that they had changed their preferences from having a bath to having a shower, and whether or not they had been offered a bath.

One person told us, "I have a strip wash, I don't have a shower or a bath as there is no hot water, hasn't been for about three weeks, it's being seen to. They fetch a jug of hot water from downstairs." Not all of the people living in the home were offered a choice of having a bath and shower whilst the boiler was not working. The registered manager told us that everyone had access to hot water as there was an immersion heater, despite the person telling us that they had not been offered a bath or shower because of the boiler problems.

People who required support to wash and dress did not always choose when to get up and go to bed. One person said, "They wake me at 7am, bring my breakfast, I then wake up at 8am and there's my breakfast, I

drink the coffee, even if it's cold." Another person said they went to bed when it was convenient to staff. It was not recorded in people's care records what times they preferred to get up and go to bed so it was not clear whether their preferences were respected from the records. This did not reflect that staff always gave people choices when to get up and go to bed.

Staff did not always provide people with individualised support. We looked in one person's care records and saw that the person had been prescribed specific exercises for their standing balance and strength. The person had been referred for physiotherapy for their falls risk as they were unsteady on their feet. We saw in accident records that the person had fallen. The therapist had handed over to staff in August 2016 that these exercises were to increase the person's mobility and safety and were to be done with staff on a daily basis. Although one staff member had written in the healthcare professional's communication record that these were to be carried out, there was not a specific care plan developed or guidance for staff. Furthermore, there was no record that staff had ever carried these exercises out with the person, and the person confirmed that they had not. We asked the registered manager about this, and they said the person was sometimes offered gentle exercise in a group activity. We asked why staff had not ever done the standing balance exercises with the person, and the registered manager said they probably did not have time. This meant that they had not been given the opportunity to enhance their quality of life through the exercises. We found that the care plan had not been updated with further guidance for staff regarding changes in the person's need.

People's care records did not always contain guidance for staff on how best to meet people's individual needs concerning their specific requirements. These ranged from PRN medicines and creating care plans with guidance for staff regarding bathing and showering preferences, and continence.

One person told us staff did not support them to use the toilet when needed. We saw that in the person's care record, staff had recorded the person had recently been incontinent, however they person told us that staff did not always give them the opportunity to support them to go to the toilet. There was not a care plan in place detailing when staff should support the person to go to the toilet, and how they should do so in order to promote the person's continence.

We found that some people had life histories filled in, however other people did not have these completed within their care records, so that staff could always support them to follow their interests. There were several areas of people's care plans which did not contain enough guidance for staff to provide them with good quality consistent care.

The registered manager was working with the quality assurance team from the local authority to create more person-centred care plans. The current care plans did not always reflect each person's needs. Therefore, in the meantime people were not always receiving individualised care that was responsive to their needs.

These concerns did not demonstrate a person-centred approach to care, meaning the home was still in breach of Regulation 9 part 1 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People we spoke with knew how to complain and said that they would speak to staff if they were unhappy. One relative said they would go to the registered manager if they were concerned about anything and felt comfortable to do so. However, they had not had any complaints they told us. We saw that the home had received a complaint recently that they had responded to appropriately. There was a complaints procedure available for people.

Inadequate

Is the service well-led?

Our findings

On our visit to the home in October 2015, we found that the registered manager had not always notified CQC of events that they were required to. Therefore they were in breach of regulation 18 of CQC Registration Regulations 2009. They were still in breach of this regulation as they had not notified us of the breakdown of the boiler and lack of central heating. We also found that they had not always notified the local authority or CQC of any safeguarding concerns, which they are required by law to do.

During our recent inspection on 28 and 29 November 2016, we looked at the monthly audits that the registered manager carried out which included infection control and medicines. We found that they did not adequately identify concerns, and therefore lead to action being taken to manage them.

Where the infection control audit had picked up problems, actions had been identified but not always completed. We saw that at times people's rooms were dirty, including dirty carpets. There was a cleaning schedule which we could see was completed each day, however we still saw that some areas were not clean. We also saw the registered manager had carried out regular room inspections. These had identified where there had been some concerns, however action had not always been taken to rectify these. Furthermore, the infection control audit had not prevented poor standards of hygiene being apparent across different areas of the home.

In the monthly medicines audit, the registered manager had specified that PRN (for 'as required' medicines) protocols were in place when they completed the medicines audit. However, we found that they were not in place for everyone who took PRN medicines. This included for the use of sedatives. The audit, therefore, was not effective at picking up all areas in need of improvement and demonstrated a lack of understanding about current best practice.

The accidents audit did not identify specific individuals who were falling regularly. The audit identified areas and times when people were having falls but did not give rise to opportunity to investigate why people were falling, and people who were repeatedly having accidents. This meant that there were no opportunities to improve safety for those people.

Staff cared for people based on what they thought rather than on the guidance from the registered manager. They were not always given adequate information to provide effective care. People`s care records did not always reflect their current needs. Care plans had not been audited so the concerns we found were not identified previously. The registered manager had not identified gaps in people's care plans, concerns about records not being up to date and risk assessments not being in place. We found that the registered manager had not checked whether people were receiving the care they required, or that staff were following recommendations for people's health and welfare. When we asked the registered manager about specific people's care needs, they were not always consistent with what other members of staff told us. We also heard staff refer to people inappropriately which had not been identified as a concern. There was no system in place for auditing care plans and checking staff competency and conduct. We found that not all people had been referred to relevant health professionals. The registered manager had not ensured that the GP

referred people on in order to gain more support, for example with regard to people's risk of losing weight or continence concerns.

We saw that the gas inspection in early October 2016 had identified the problem with the boiler and issued a warning notice, and it was unclear why this had taken so long to repair. However, no risk assessments had been carried out regarding the use of portable heaters whilst the boiler was not working.

We asked following our visit if there were any further audits which were carried out by the provider, and they sent us an audit which they carried out on the 16 November 2016. It had identified some issues, for example, that there was a photo missing from one person's MAR. On 28 November, this had still not been added. The audit had not picked up any further concerns that we found.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Safeguarding matters were not dealt with in an open, transparent and objective way. It transpired immediately following our visit that on 28 November, the same day we visited, a person had left the home without staff realising. The person was found at 5am having left the home during the night and walked several miles. During our visit the registered manager did not give us this information.

There was poor leadership in place. People gave us mixed feedback about whether or not the registered manager was visible around the home. One person said, "The manager is [registered manager], we don't see much of them. It could be better run." Another said, "I don't think I do know the manager." However, another two people said they knew who the deputy manager and the registered manager were and could speak to them if they wanted to.

Some staff we spoke with did not always feel supported at work by the management team. This was because they did not always feel that the registered manager supported them and that information about them was not always kept confidential, and that they felt the management team talked about their personal problems with other staff. Another member of staff we spoke with said that they did not always feel appreciated by management and the provider. All of the staff we spoke with said that the care team worked well together and they supported each other as a team.

We spoke with the registered manager about staffing levels, and they told us that at present because there were only 17 people living there, they were going to drop staffing levels by four to three care staff during the day. They said that this met the legal minimum required. However, there is not a legal minimum requirement. It is the provider's responsibility to adequately assess staffing requirements according to people's needs, as well as keep up to date with best practice and knowledge.

The registered manager was unable to explain how people's needs would be met with three members of staff. They then agreed to talk with the provider and reconsider whether this would effectively meet people's needs. After our visit, they said that they would keep the present number of staff. The registered manager told us they felt there were enough staff. There was not a system in place which had identified that staffing presented a concern and they did not carry out any audits in relation to staffing. Staff who told us they were short of staff had not been listened to by the registered manager.

The concerns we found had not all been raised by individuals living in the home. Although some people attended meetings and gave some feedback on the home itself, they were not proactively asked their opinions on the different aspects of the care provided to them and made aware of any opportunities which

may be available to them. An example of this was that the registered manager told us people had a choice of what they could eat. We spoke with people who were not aware of this.

We found that not all the information given to us in the PIR we received prior to the inspection was accurate.

The concerns we found demonstrated a lack of understanding of good quality assurance systems and how they can contribute to improvement. We found that there was not a drive for improvement as we found additional breaches to what we found in our inspection in 2015.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service had not notified us of events they are required to notify us of.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care based on their individual needs. Regulation 9 (a), (b) and (c), 3 (a), (b), (c), of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Where people were at risk of not eating and drinking enough, care plans were not in place in respect of this and the appropriate health professionals were not always involved. Regulation 14, part 1 and 4(a), (b) and (d) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always protected against risks associated with poor deployment and low

number of staff.

Regulation 18, part 1,of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 Risks to people's health and safety had not been adequately assessed or mitigated. Regulation 12, parts 1 and 2 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

We have issued a warning notice to the provider and registered manager, and asked them to be compliant with this by 31 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the service were not effective and recording was not accurate. Regulation 17 part 2, (a), (b) and (c) and (f) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

We have issued a warning notice to the provider and registered manager, and asked them to be compliant with this by 28 February 2017.