Care Quality Commission

Sycamore Cottage Limited

# Sycamore Cottage Residential Home

**Inspection report**

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Good** |
| Is the service safe? | **Good** |
| Is the service effective? | **Good** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Requires improvement** |

## Overall summary

We carried out an unannounced inspection of this service on 21 November 2014. Nine breaches of legal requirements were found and we issued a warning notice for one of these. We asked the provider to send us an action plan to state how and when these improvements would be made,

On 30 January 2015 we carried out a further unannounced inspecting of this service to check that action had been taken to address the breaches of regulations and meet the warning notice. We found that improvements had been made to meet the relevant requirements.

You can read a summary of our findings from both inspections below.

**Comprehensive inspection 21 November 2014**

This inspection took place on 20 November 2014 and was unannounced.

# Summary of findings

Sycamore Cottage provides residential care for up to 14 older people some of whom have mental health needs. Accommodation is on two floors with a stair lift for access. There is a communal lounge/dining room and a conservatory which opens onto a secure garden.

At our last inspection on 24 September 2014 we found that the people who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises. We made a requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 for the provider to put this right.

We told the provider to send us a report by 21 November 2014 telling us what action they were going to take to make improvements. The provider failed to do this.

At this inspection we found that not all the required work had been done to make the areas we identified safe and some of the risks remained.

Sycamore Cottage is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection a registered manager was not employed at the service.

People's safety was being compromised in a number of areas. These included the management of moving and handling, pressure sore care, risk assessing, and the management of nutrition.

There were not enough staff to keep people safe and meet their needs and the provider did not operate an effective recruitment procedure. People were not protected against the risks associated with the unsafe use and management of medicines.

The provider was not always following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. Consequently they had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for two people, even though their liberty was being significantly restricted.

Care workers had completed a range of training relevant to their roles and responsibilities. However on one occasion they had not been able to put their training into practice due to not having the equipment they needed.

People's privacy and dignity was not always respected and promoted. Although some staff cared for people in a respectful and dignified way, we saw that others did not. Sensitive personal information about the people who used the service and staff was sent by email to a person who had no reason to receive this information.

Some people were socially isolated in the home and did not have access to meaningful activities. This was because they were confined to their bedrooms or because activities weren't being provided. Care workers said they did their best to help people follow their hobbies and interests but weren't always able to do this due to lack of time.

The arrangements in place to assess and monitor the quality of the service were ineffective. As a result issues with plans of care, medication, and health and safety had not been identified or addressed.

We observed lunch being served and people told us they enjoyed their meal. The food was well-presented and nutritious and people had a choice as to what they ate.

During our inspection we found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

**Focused inspection 30 January 2015**

This inspection was unannounced. There were seven people living at the home at the time of this inspection.

Sycamore Cottage is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection an acting manager was in post who had not yet applied for registration with us.

Following our inspection on 21 November 2014 we issued a warning notice to the provider. This is a notice to providers informing them they are breaching a regulatory

# Summary of findings

requirement. The warning notice told the provider to take proper steps to ensure that people wo used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.The provider had until 29 December 2014 to meet this. At this inspection we found the warning notice had been met.

We also told the provider to make improvements to staffing numbers, recruitment procedures, the management of medication, consent to care, privacy and dignity, meeting people's needs, unsafe premises, monitoring the service, and reporting serious incidents to us. At this inspection we found that action had been taken and improvements made in all these areas.

People who needed assistance to move about the home were being safely supported to do this. They had the equipment they needed and appropriately trained staff to help them. During the inspection we saw that care workers assisted people to move safely and in their own time.

People had up to date risk assessments and plans of care in place to help ensure they were cared for properly. Staff worked closely with local health care professionals to provide appropriate care. People had been re-assessed with regard to their eating and drinking needs and those who needed extra calories to build them up were provided with fortified food.

The providers had increased staffing levels. We saw that care staff had the time they needed to care for people safely. If people needed assistance this was provided promptly and at no time were people left unsupported. When people needed two care workers to assist them they were provided.

Recruitment policies and procedure had been reviewed and improved. The provider and the acting manager said these would always be followed, and staff would only work in the home if they had the necessary background checks. This will help to ensure that all staff employed are suitable to work with people receiving care.

People had their medicines safely and in the way they wanted it .Improvements had been made to the way medication was managed in the home. All medication records and documentation had been reviewed and updated, where necessary, by the acting manager.

Staff treated people with dignity and respect. People were wearing clean clothes they had chosen themselves. Staff encouraged people to be actively involved in making decisions about their care, treatment and support.

People told us staff had the time to support them with their hobbies and interests. During the inspection we observed staff playing cards with people, looking at books with them, and talking with them about their lives. The plans of care we looked at were personalised and included information on how staff could support people with their activities.

The acting manager and provider both checked all aspects of the service to make sure it was running safely and effectively. If any issues were found these were quickly dealt with. For example the acting manager told us one person's room appeared 'unloved' so it was promptly re-decorated.

All the people we spoke with said the service had improved dramatically. Both people using the service and staff told us about the many changes for the better they had seen. All said they were happy to continue living and working in the home.

# 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?

Good

**Comprehensive inspection 21 November 2014**

The service was not safe.

The provider did not protect the people who used the service against the risks of receiving care or treatment that was inappropriate or unsafe.

The provider did not ensure that there were sufficient numbers of suitable staff on duty.

The provider did not protect service users against the risks associated with the unsafe use and management of medicines.

**Focused inspection 30 January 2015**

The service was safe.

The people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

There were sufficient numbers of suitable staff on duty to meet people's needs.

### Is the service effective?

Good

**Comprehensive inspection 21 November 2014**

The service was not always effective.

The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of the people who used the service.

Staff had been trained to provide appropriate care and support to the people who used the service.

Some people who used the service told us they enjoyed the food served at the home.

Most people had been supported to maintain their health and had access to ongoing healthcare support.

**Focused inspection 30 January 2015**

The service was effective.

The provider had suitable arrangements in place for obtaining, and acting in accordance with, the consent of the people who used the service.

Staff had been trained to provide appropriate care and support to the people who used the service.

The food served was well-presented and appetising and people said they enjoyed it. People nutritional needs were being met.

# Summary of findings

People were supported to maintain their health and had access to ongoing healthcare support.

## Is the service caring?

Good

**Comprehensive inspection 21 November 2014**

The service was not always caring.

The privacy and dignity of the people who used the service was not always respected and promoted.

Some of the care workers employed at the home were exceptionally kind and caring.

The people who used the service were mostly supported to express their views and be actively involved in making decisions about their care, treatment and support.

**Focused inspection 30 January 2015**

The service was caring.

The privacy and dignity of the people who used the service was respected and promoted.

Staff were kind and caring. They listened to what people wanted and involved them in the life of the home.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

## Is the service responsive?

Good

**Comprehensive inspection 21 November 2014**

The service was not always responsive.

The provider had not ensured that people's emotional and social needs were met and plans of care had not always taken these in to account.

The provider's complaints procedure was in need of improvement as it did not give people all the information they needed to make a complaint.

**Focused inspection 30 January 2015**

The service was responsive.

People's emotional and social needs were met. Staff supported them to do activities and follow their individual hobbies and interests.

The provider's complaints procedure had been reviewed and updated so people had the information they needed if they wanted to make a complaint.

## Is the service well-led?

Requires improvement

**Comprehensive inspection 21 November 2014**

# Summary of findings

The service was not well-led.

The provider had not ensured that a registered manager was in charge of the home despite this being a condition of the provider's registration.

The provider's arrangements to regularly assess and monitor the quality of the service were ineffective.

The provider had not notified CQC of allegations of abuse involving the people who used the service.

**Focused inspection 30 January 2015**

The service was well-led.

The provider had appointed a new acting manager. At the time this report was written the acting manager had not yet applied to be registered with us.

The provider had effective systems in place to assess and monitor the quality of the service.

The provider had notified CQC of changes, events and incidents that had occurred at the service.

# Sycamore Cottage Residential Home

**Detailed findings**

## Background to this inspection

**Comprehensive inspection 21 November 2014**

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 unannounced inspection took place on 20 November and was carried out by two inspectors.

Before the inspection we reviewed the information we held about the service and spoke with staff at the local authority. They raised concerns about care, staffing, and leadership at the service.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing support in the lounge and dining room. We spoke with five people who used the service and one relative. We also spoke with the acting manager, four care workers, and two management consultants who were working with the provider at the time of our inspection.

We looked at six people's care records, incident reports, medication records, menus, and policies and procedures. We also looked at staff records, duty rosters, and the provider's statement of purpose. This is a document which includes a standard required set of information about a service.

**Focused inspection 30 January 2015**

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 30 January 2015 and was unannounced. It was carried out to check that action had been taken to address the breaches of regulations and meet the warning notice issued at a previous unannounced inspection on 21 November 2014.

This inspection was carried out by one inspector. Prior to the inspection we reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We used a variety of methods to inspect the service. We met with all the people who used the service. Some people we met were unable to give their views due to their mental health needs so we spent time with them and observed the support they received.

We also spoke with the acting manager, provider, and two care workers. Prior to the inspection we exchanged information with the local authority responsible for commissioning services at this home.

# Detailed findings

We observed people being supported in the lounges and in the dining areas at lunch time. We looked at records relating to all aspects of the service including care, staffing and quality assurance. We also looked in detail at three people's care records.

Good

# Is the service safe?

## Our findings

**Comprehensive inspection 21 November 2014**

On the day we inspected one person who used the service did not have the moving and handling equipment they needed to help ensure they could move about the home safely. As a result they were confined to their room with staff checking them on an hourly basis. They had been assessed as needing a hoist but did not have one in place. The acting manager said one had been ordered but it had not yet arrived at the home.

During our inspection this person fell and was unable to call for help easily as their call bell was out of reach. In addition, staff who went to help them could not do this safety due to not having the correct moving and handling equipment available. The person was extremely distressed and asking repeatedly to be helped up. In order to do this staff used a partial drag lift which they said they knew was not safe but felt they had no option as waiting for paramedics would increase the person's distress. When we checked records we found this person did not have an up to date risk assessment or care plan in place for their current moving and handling needs so staff had no guidance to follow in doing this safely.

Furthermore, this person had been assessed as being at risk of pressure sores and had begun to develop one. However some of the pressure relief equipment they needed was not yet in place. Although they had a pressure relieving mattress for their bed, they did not have a pressure relieving cushion for their chair, despite using it daily. Records indicated they had been showing signs of developing a pressure sore over the previous six days. The acting manager said the necessary pressure relief equipment had been ordered and was due to arrive the next day. This meant that if the equipment did arrive the next day the person would have waited a week for it and an updated risk assessment about this delay was not in place.

We looked at records of how people were supported with their nutritional needs. Two people were recorded as having a low body mass index (BMI). A BMI is an indicator of a person's state of health and a low BMI can indicate that a person is at risk of malnourishment. There was no documented evidence that either of these two people's nutritional needs were being effectively monitored or of any other steps being taken to address their low BMIs. This meant that we could not be sure that these people's nutritional needs were being met.

These are breaches of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not take proper steps to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

During our inspection we found there were not enough staff to keep people safe and meet their needs. There were two care workers on duty for eight people, despite care records identifying that four of these people needed two staff to assist then with personal support. This meant that when care workers were providing this personal support all the other people who used the service were left unattended. Our observations during the inspection further supported this.

On a number of occasions people were put at risk due to a lack of staff. At one point two care workers were assisting a person to sit up. Halfway through this manoeuvre one of them was called away urgently to assist another person. This left their colleague and the person stuck mid-manoeuvre whilst waiting for the other staff member to return. During this time the person being assisted began to slide back into a prone position and appeared uncomfortable and anxious.

At another point two care workers were assisting a person in their room. This left the people in the communal lounge/dining area unsupervised. During this time one person went out in the garden in the dark. And another person, who needed assistance to walk, began walking on their own. We alerted staff and they rushed back to assist these two people to safety.

Staff, including the acting manager, told us they were concerned about staffing levels in the home. One staff member said, "We are run off our feet. I am worried there is going to be an accident because we can't be in two places at once." Another commented, "Most of the residents need two staff so if we're seeing to them everybody else gets left on their own."

The rota showed there were two care workers on duty day and night assisted by the acting manager who worked weekday office hours, and a part time cook and cleaner.

Good

# Is the service safe?

Staff said they thought the situation was 'worse' at weekends because the acting manager did not work then so there was nobody extra on site who could help out if needed, although the acting manager was on call.

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not ensure that there were sufficient numbers of suitable staff on duty.

On the day of our inspection an acting manager was in post assisted by a management consultant. This acting manager subsequently left the home the day after our inspection. A person appointed by the provider to run the home replaced them with another acting manager. The new acting manager was allowed to work in the home without having the necessary pre-employment checks. During this time they had access to the personal data of the people who used the service. Following pre-employment checks this person's employment was terminated. This left the management consultancy responsible for the day to day running of the home.

By allowing a person to work in the home without the necessary pre-employment checks, the provider put the people who used the service at risk of being cared for by unsuitable staff.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not operate an effective recruitment procedure.

We observed a care worker giving out medication at lunchtime. This was given out 45 minutes late. The care workers said this was because they had been busy doing other essential tasks. During the medication round the care workers was called away from this task three times to assist with people who needed personal support. We were concerned that this staff member was subject to so many distractions. Despite this they were caring and professional at all times, making sure people had their medication safely and calmly, and locking the medication trolley each time they had to leave it.

At a previous inspection in June 2013 we found there were no protocols or plans of care in place for PRN ('as required' medication). This meant that there was nothing in writing to explain to staff the circumstances under which PRN medication should be offered, how often it should be offered, and any potential side effects. This meant that there was a risk that people's PRN medication might not be administered safely which presented a possible risk to the safety and welfare of people using the service.

At this inspection we found that although there were some PRN protocols in place, these were not always being followed. For example, one person had an undated PRN in protocol in place for a medication they were no longer on and there was no PRN protocol for a PRN medication they actually were on. When we looked at records for how this had been administered we saw that the reason for it having been given had only been recorded on two out of the 12 occasions it had been given.

Another person had four undated PRN protocols in place. The first was for a controlled drug and the reason for it having been given had been properly recorded on each occasion. The second was for a medication this person was no longer on. For the third the reason for the medication being administered was only recorded two out of six times. For the fourth the reason for the medication being given was not recorded at all. Records stated this person's medication should be reviewed monthly but there was no evidence of any reviews being carried out.

By failing to manage PRN medication properly people were put at risk of not having their PRN medication when they needed it, or of being given it when they did not need it. We reported this to the local authority and at the time of this inspection they were investigating it as a safeguarding issue.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not protect service users against the risks associated with the unsafe use and management of medicines.

**Focused inspection 30 January 2015**

We found that the provider had met the legal requirements in relation to care and welfare, staffing levels, recruitment procedure, and the management of medication.

We looked at the care of people who needed moving and handling equipment to assist them when transferring. We found that the appropriate equipment was in place. This included profiling beds, hoists, 'stand-aids', and slings.

The provider had taken action when people needed assistance to move about the home. For example, since we

Good

# Is the service safe?

last inspected one person had been observed as being unsteady on their feet. In response the acting manager had arranged for this person to be assessed by an occupational therapist. They had recommended this person had specialist moving and handling equipment and the provider had obtained this.

One person used a mobility aid to assist them when they walked. Their care plan stated this should always be near them. We observed that staff made sure this was the case and continued checking throughout the day to make sure the aid was close at hand for the person to use if they needed to.

Records showed that people had up to date risk assessments and plans of care in place to help ensure they were cared for safely. For example, people who were at risk of developing pressure sores were being carefully monitor and supported. One person had particular care needs relating to a pressure area. Records showed that staff worked closely with a local district nursing team to provide this and were being trained by the district nurses to provide some of the care themselves.

We looked to see if there were sufficient numbers of staff on duty at the home. Records showed that staffing numbers had increased for both care and ancillary staff. We observed that care staff had the time they needed to care for people safely. If people needed assistance this was provided promptly and at no time were people left unsupported. If people needed the support of two care workers to assist them at any time this was provided.

People told us staffing levels had improved. One person said, "I've noticed the staff have more time with us." A care worker told us the increase in staffing levels had had a positive effect on the people who used the service who were now 'much happier'. They said that one person who had previously resisted personal care was now accepting it. They said, "I think it's because they're more content now and more occupied. They're a lot calmer because we have time with them."

The acting manager said she worked office hours but also came to the service during the evenings and at weekends to check on staffing levels and other aspects of the service. She told us, "I'm not a nine to five person and I need to make sure there are enough staff to care for people properly so I make a point of checking that everything is OK when I am not officially working."

Recruitment policies and procedure had been reviewed and the provider and the acting manager said these would always be followed. They said that no person would work in the home without the required checks being carried out to help ensure they were safe to work with people receiving care. Records showed that one person had been employed by the home since we last inspected. They had been safely recruited with all the necessary background checks being carried out.

Since we last inspected improvements had been made to the way medicines was managed in the home. All medication records and documentation had been reviewed and updated, where necessary, by the acting manager.

We observed part of the medication round. Care workers administered people's medication on time and in a calm and unhurried manner. At no time was the care worker giving out the medication distracted or called away from their task. This meant the care worker was able to concentrate on what they were doing and ensure people had their medication safely and in the way they wanted it.

At our two previous inspections 'as required' (PRN) medication protocols were not fit for purpose. Some were not in place or, if they were in place, they were not being followed. Some were undated and/or no longer relevant as people's medication had changed. At this inspection all PRN protocols had been checked, improved where necessary, and followed. If people needed this type of medication staff recorded the reasons for this. This meant that people were having their PRN medication when they needed it with a clear audit trail showing why this was.

Good

# Is the service effective?

## Our findings

**Comprehensive inspection 21 November 2014**

Some people who used the service were not able to make certain decisions about their care due to living with dementia. However plans of care showed a lack of understanding about how this should be addressed. For example, two people's records stated they were not able to make certain decisions. However, neither person had had an assessment of their mental capacity. This meant that the Mental Capacity Act 2005 Code of Practice had not been followed when assessing their ability to make decisions.

One person living at the home at the time of our inspection had been referred to the local Deprivation of Liberty Safeguards (DoLS) team. This was because they were subject to a high level of supervision and control that may have amounted to deprivation of their liberty. A DoLS authorisation was in place for this person. However two other people, also subject to a high level of supervision and control, had not been referred to the team. This meant that correct procedures had not been followed to help ensure their liberty was not restricted unnecessarily.

These are breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

We looked at staff training records. These showed that care workers had completed a range of training relevant to their roles and responsibilities. This included training to keep people safe including moving and handling, infection control, food hygiene, and fire safety. In addition, records showed that care workers had either completed or were undertaking qualifications in health and social care.

We spoke with two care workers. They both told us they were satisfied with the training they had received at the home. One told us, "The training has helped me to do my job, especially the practical training." The other care worker told us, "My training has been helpful. It's given me an understanding of Alzheimer's and of how people communicate." We saw from a summary of training that most staff attended the same courses as the care workers we spoke with. This meant they had had training that was relevant to some of the needs of the people they supported.

They both said they'd had training on the Mental Capacity Act and although they understood some of the principles they said they were unclear how to refer a person to the local Deprivation of Liberty Safeguards (DoLS) team. They said that if this was required they would ask the person in charge of the home at that time to do this.

In addition, although staff had had appropriate training they had not always been able to put this into practice due to not having the equipment they needed. Prior to our inspection the local authority reported to us that two staff members had allegedly resorted to 'drag lifting' (an unsafe moving and handling procedure that puts the person being assisted and the staff assisting them at risk) due to not having the use of an appropriate hoist available. The local authority was investigating this incident at the time this report was being written.

We observed lunch being served both in the dining area and in the lounge where some people had chosen to eat. Staff assisted those who needed help with their meal. The food served was prepared in the way people wanted it, for example if they were on a soft diet their food was the right consistency for them. People were encouraged to take their time over their meal and to socialise while they were eating.

People told us they enjoyed their lunch. Comments from four people included: 'The food is nice and hot and looks lovely'; 'Excellent chef here'; and 'I enjoyed that [meal]'. People had a choice of main course, dessert, and drinks. Staff respected people's choices, for example one person wanted a mix of fruit juices and staff helped them to make this drink up.

Menus were planned in advance to ensure a variety of meals were served so people received a nutritionally balanced diet. Care workers told us there were always alternatives available if someone didn't like the food available. The menu was displayed on the wall in the dining room. However it appeared that only one person who used the service was able to read the menu which was in small print. This meant that other people did not know what was being served that day until staff told them.

Good

# Is the service effective?

We saw from plans of care we looked at that most people had been supported with their health and well-being. Care workers had been attentive to some signs of changes in people's health. For example, when a person displayed behaviour that was unusual for them staff had arranged for the person's doctor to visit to review their medication. And a GP had been called out to see another person who had a suspected infection. We saw evidence that staff mostly had acted on advice given by visiting health professionals.

**Focused inspection 30 January 2015**

We found that the provider had met the legal requirements in relation to the implementation of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

The acting manager was aware of her responsibilities with regard to this legislation and had taken action to ensure the MCA Code of Practice was followed at the service. She said she had also been in discussion with care workers to ensure they understood what the legislation meant for the people they supported.

Records showed that since our last inspection all the people who used the service had been assessed to see if they had the mental capacity to make specific decisions. Those who might lack the mental capacity to do this had been referred to the local DoLS team for a formal assessment of their mental capacity.

This meant that people who might lack capacity to make specific decisions were protected and the relevant agency informed of this so independent support could be provided where necessary.

Since we last inspected all the people who used the service had been re-assessed with regard to their nutrition and hydration needs and new plans of care and risk assessments put in place. All had charts that recorded their intake of food and drinks and those with a low body mass index (BMI) were on supplements. A BMI is an indicator of a person's state of health with regard to their weight and a low BMI can indicate that a person is at risk of malnourishment.

The acting manager told us some food was fortified to increase people's calorie intake. For example, cream was poured on cornflakes and butter added to potatoes. The acting manager said fortifying food in this way was preferable to using prescribed fortified drinks as the people who used the service did not always like these**.** All the people who used the service were weighed monthly and records showed that no-one had suffered any significant weight loss.

Good

# Is the service caring?

## Our findings

**Comprehensive inspection 21 November 2014**

People's privacy and dignity was not always respected and promoted. Although some staff cared for people in a respectful and dignified way, others did not.

One person, identified at the inspection, was wearing stained nightwear and had been given a drink in an infant's plastic drinking cup. Another person was given a children's picture book to read. Staff said the person liked this book but if they had access to more suitable books they would have chosen something different. We also saw the acting manager standing above a person in a chair and spooning food into their mouth. The latter was of particular concern because this poor practice was raised as an issue at our previous inspection and we asked the provider to address it.

These were all examples of people receiving care that was either disrespectful or compromised their dignity.

In addition, following our inspection, sensitive personal information about the people who used the service and staff was sent by email by a person appointed by the provider, to a person who had no reason to receive this information.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not ensure the dignity and privacy of the people who used the service was maintained.

We observed that some of the care workers employed at the home were exceptionally kind and caring. One in particular went to great lengths to provide quality care to the people who used the service. We saw this care worker got on well with all the people who used the service, was knowledgeable about their needs, and always kind and patient when they provided support. However the time staff had to spend with people to provide quality care, at the pace people required was restricted due to their workload. One person told us "They (the care workers) are literally run off their feet. They work very hard but the odds are against them."

We observed that, where possible, staff encouraged people to be involved in decisions about their care. For example, staff consulted verbally with people before providing care for them and helped them decide how they would like to be supported. For example, we saw staff assisting people with choosing food and drinks, and deciding whether to sit in the lounge or dining area at lunchtime.

We talked with staff about how they supported people who were unable to communicate their needs verbally. Staff told us they referred to plans of care and what they knew about the person from working with them. We observed one care worker supporting a person with limited verbal communication. We saw they were gentle, patient, and caring in their approach, explaining what they were doing, and constantly asking the person's permission to assist them.

We looked at how the service supported people to express their views and be actively involved in making decisions about their care, treatment and support.

Care workers told us about how they learnt about people's needs and how they wanted to be supported from their plans of care. One care worker told us, "I get to know service users from reading their care plans and from talking with them. I know their life histories and about things they like."

The acting manager told us the home held 'residents meetings' to give the people who used the service the opportunity to comment on how it was run. However she was unable to produce any documentation to evidence this. She also said that as it was a small home she was able to talk to all of the people who used the service every day she was in work. She said this enabled her to hear people's views on the home individually.

**Focused inspection 30 January 2015**

We found that the provider had met the legal requirements in relation to maintaining the dignity and privacy of the people who used the service.

One person who used the service told us, "I'm overjoyed to be here now because staff treat me like a human being not a number." They said the acting manager had a caring approach and was a good role-model for staff. They told us, "She is wonderful with [a particular person living with dementia] I've seen her helping them and she is lovely with them."

At lunch time staff sat with people while they ate, providing assistance when it was needed. People were encouraged to

Good

# Is the service caring?

take their time with their meals and to talk with staff and the other people who used the service if they wanted to. People were supplied with appropriate and dignified eating and drinking equipment to assist them with their meals.

People were dressed in clean clothes they had chosen themselves. Care workers were providing daily hand and nail care for people who wanted it. Some people who wanted to were assisting with domestic tasks like cooking, dusting and folding clothes. Staff said this helped keep them active and involved in the life of the home.

The acting manager had written to all the people who used the service, or their relative where appropriate, to invite them to spend time with staff going through their plans of care to check if they were acceptable to them. This demonstrated that people were being actively involved in making decisions about their care, treatment and support.

Information about the people who used the service was kept securely. Staff followed the provider's confidentiality policy and understood their responsibilities under the Data Protection Act.

Good

# Is the service responsive?

## Our findings

**Comprehensive inspection 21 November 2014**

One person spent the day of our visit alone in their room. This was not their choice and they repeatedly asked to go downstairs to the lounge. However staff could not move them safely (see 'Safe') so they had to stay where they were. Although staff went in to check this person at regular intervals, they had no other company or meaningful activities available to them. They told us, "I'm lonely up here on my own." Their plans of care did not take into account they were currently confined to their room, and nothing was done to address their social isolation apart from their usual observational checks.

Another person was also confined to their room during our inspection due to being on bed rest. Records showed their physical and medical needs were being met, but there was nothing in their plans of care to say how staff should meet their emotional and social needs. Staff said they did their best to engage with this person when they went to check them but lack of time made this difficult. Consequently we could not be assured these needs were being met.

After lunch one member of staff did their best to involve one person who was in the lounge in an activity. They looked at a book with them, which this person seemed to enjoy. Another person was reading on their own and the acting manager talked with them about the book they were reading. However we saw no other activities offered to anybody else. We observed two people making up their own activity by collecting empty juice cartons and lining them up on a table. It was of concern that these people did not have anything more meaningful with which to occupy themselves.

All the care workers we spoke with said they would like to help people engage in activities and follow their hobbies and interests. However they said they were rarely able to do this due to the amount of care tasks they had to do. One care worker said, "It's very frustrating because our residents are interested in all sorts of things but we can't help them because we don't have time."

This is a further breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not ensure that the individual needs of the people who used the service were met.

The provider's complaints procedure was displayed on the noticeboard in the reception area and also printed in the statement of purpose. This meant it was accessible to visitors and some of the people who used the service. Other people who used the service were not able to use it due to their mental health needs. The acting manager said that to compensate for this the complaints procedure was explained to people verbally and staff advocated for people who may not be able to use it.

During the inspection a care worker told us that one of the people who used the service had a concern and wanted to speak to us about it. This showed that staff were advocating for people. We looked into this and found that the complaint had already been satisfactorily resolved to the satisfaction of the person in question. This showed that the matter had been taken seriously and followed-up by staff.

Some improvements were needed to the provider's complaints procedure. Information advised complainants to make complaints to the manager and, if not satisfactorily resolved, the provider. It did not inform people that complaints could be taken at any time to the local authority, bypassing the manager and provider if necessary. This meant that if people had a complaint about the manager or provider they would have nowhere to take it.

The complaints procedure also contained an inaccurate description of the role CQC and the local authority had in complaints investigation. This meant that people may not have all the information needed to raise their concerns to the appropriate people.

**Focused inspection 30 January 2015**

We found that the provider had met the legal requirements in relation to ensuring that the individual needs of the people who used the service were met.

People told us staff had the time to support them to do activities. During the inspection we observed staff playing cards with people, looking at books with them, and talking with them about their lives. One person told us, "The new manager comes and watches television with us which is lovely." They also said entertainment was being provided. They said, "We had singers come in yesterday to perform 'old time' songs. We really enjoyed that so staff have booked them again to come every month."

Good

# Is the service responsive?

Staff told us that since our last inspection they been given more time to socialise and do activities with the people who used the service. One staff member told us, “Our residents like to read and look at books and play cards. They like to keep their brains active. We can help them with that now.”

People’s plans of care had been reviewed, re-written, and improved. One care worker told us, “Care plans are really good now. We’ve got everything in one folder and much better information about people’s care needs.” The plans of care we looked at were personalised and included information, in the form of an ‘activity plan’, on people’s hobbies and interests and how staff could support them with these.

The provider’s complaints procedure had been reviewed and improved to make it clearer and easier to use.

Requires improvement

# Is the service well-led?

## Our findings

**Comprehensive inspection 21 November 2014**

At our last inspection on 24 September 2014 we found that the people who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises. We made a requirement under Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 for the provider to put this right.

We asked the provider to send us an action plan outlining how they would make improvements. However they failed to do this.

At this inspection we found that not all the required actions had been taken in order to make the areas we identified safe and some of the risks remained.

These included a hook lock on the outside of a bedroom door, which meant it could be locked from the outside (staff were unable to tell us the purpose of this but agreed that it was inappropriate); two unprotected plug sockets that were in use and level with where a person would lie in bed and within easy arms reach of them; and rough boxed piping in the narrow space between a bed and a wall that could be risky if a person fell or got out of the bed during the night.

This is a continuing breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The people who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

There were ineffective arrangements in place to regularly assess and monitor the quality of the service. The acting manager told us they carried out daily, weekly and monthly audits (checks) on key aspects of the home including plans of care, medication, and health and safety.

We checked the audits and found they had not identified shortfalls in plans of care, medication, and health and safety. For example, some people's plans of care had been reviewed by the acting manager and judged to be satisfactory. However changes to these people's needs, evident from daily records, had not been incorporated into their plans of care. This shortfall had not been identified by the audits.

Medication audits had failed to identify poor practice with regard to PRN ('as required') medication. We also noted that medication audits were only carried out on weekdays, which meant that problems at weekends might not be identified in a timely manner. Health and safety checks had failed to identify potential risks in the home, for example an unguarded hot radiator in the ensuite of a bedroom used by one of the people who used the service.

These shortfalls meant the provider's arrangements to regularly assess and monitor the quality of the service were ineffective and as a result issues with plans of care, medication, and health and safety had not been identified or addressed.

This is a breach of Regulation 10 (1) of the Care Quality Commission (Registration) Regulations 2009. The registered person did not have an effective system in place for assessing and monitoring the quality of the service.

It is a condition of the provider's registration that the service is managed by an individual who is a registered manager. When we inspected it had been without a registered manager for six months. During that period it was run by an acting manager who did not apply for registration with us. On the day of our inspection the acting manager was still running the home in conjunction with a management consultancy brought into the home the previous day.

Registered persons are required to notify CQC of certain changes, events and incidents at the service including allegations of abuse and serious injuries to the people who use the service. Our records showed that CQC had not received any notifications from the service since July 2014.

However the local authority had informed us of six safeguarding concerns (relating to four different people) since then. None of these had been reported to us even though the provider had a duty to do this. This meant that CQC had not been made aware of untoward incidents in the home.

This is a breach of Regulation 18 (1) (2) (e) of the Care Quality Commission (Registration) Regulations 2009. The registered person did not notify us of allegations of abuse involving the people who used the service.

The acting manager told us people's views about the service were sought through daily dialogue, care reviews, and through six-monthly written surveys. The surveys did

# Is the service well-led?

not include questions about people's privacy, dignity, independence and fulfilment which were aims that the provider set out in their statement of purpose. This meant that the survey was not an effective method assessing whether the provider's aims were met.

In addition there was no evidence that the findings of the latest two surveys, carried out in March 2014 and October 2014, had not been taken into consideration in the running of the home. Several people had rated aspects of the service as average, which showed there was potential for improvement. But no actions had been identified and implemented as a result of the survey.

**Focused inspection 30 January 2015**

We found that the provider had met the legal requirements in relation to the safety of the premises, monitoring the service, and notifying CQC of safeguarding incidents in the home.

The hook lock on the outside of one bedroom door had been removed and the unprotected plug sockets in another bedroom had been made safe. The bedroom with rough boxed piping in situ was unoccupied and in the process of being completely refurbished. The acting manager said the piping would be appropriately covered up and made safe before another person moved in.

Records showed that both the acting manager and the provider were involved in monitoring the quality of the service. The acting manager checked people's care records every day to ensure they been appropriately supported. She also checked that any charts relating to their care, for example food and fluid charts, had been competed properly. She audited medication records and stocks both daily and weekly. She said that as a result of reviewing the medication audits she had changed the medication system to a more effective one.

The acting manager said she regularly checked the premises. She told us, "Every day when I come in I do a 'walk around' to see what needs doing. If I see something I act on it. For example I noticed [named service user's] room looked unloved. I told the provider and they got it re-decorated." One person who used the service said, "The new manager has rearranged the lounge and made it better for us. One person who didn't used to be able to see the television can now."

The provider visited the home once a week to check records and speak to the people who used the service and staff. They also carried out monthly audits of care and staff records, medication, equipment, the premises, and health and safety. The people who used the service and staff were spoken with during these audits and asked for their views. This audit system meant the provider had an overview of the service so it could be assessed and monitored.

The people who used the service, staff, and the acting manager said the provider was closely involved in the running of the home. One of the people who used the service told us the provider had arranged a party for them because they knew that was what they wanted. They said the provider had brought some of their own family members to the party and the person said they were pleased about this. A care worker commented, "We see a lot of the providers now. They're lovely."

People told us the acting manager had had a positive impact on the home. One person who used the service said, "The new manager is very hands on. I've even seen her pick up a piece of paper from the floor rather than tell the care staff to do it." A care worker commented, "The new manager is brilliant. Everything has improved. She knows her job and helps on the floor. She supports the staff and is approachable. She's just what we needed."

All the people we spoke with said the service had improved dramatically. One person who used the service told us, "It's excellent here now, everything has improved and I never want to leave this home." A care worker commented, "I love it here now. It's the best it has ever been without a shadow of doubt. I can do my job and spend time with the residents."

It is a condition of the provider's registration that the service is managed by an individual who is a registered manager. When we inspected the provider had appointed a new acting manager. At the time this report was written the acting manager had not yet applied to be registered with us.

It is recommended that the provider puts a registered manager in place without delay.

Registered persons are required to notify CQC of certain changes, events or incidents at the service. Records showed that since our last inspection the provider had notified CQC of changes, events or incidents as required.