Mrs A E Palmer

Germaina House

Inspection report

4-5 St Vincent Terrace
Redcar, TS10 1QL
Tel: 01642 475740
Website:

Date of inspection visit: 16 July, 20 July & 21 August 2015
Date of publication: 21/12/2015

Ratings

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

Overall summary

This inspection took place on 16, 20July 2015 and 21 August 2015. The first day was unannounced which meant the staff and provider did not know we would be visiting. The provider was informed we would be returning for the second day of inspection. On the third day the provider was unaware that we would be visiting and we commenced the visit at 6 am.

Germaina House can provide accommodation for up to 18 people who need require help and support with personal care. The service is made up of two large Victorian mid-terraced houses which have been converted in a residential area of Redcar. There are stair lifts on each set of stairs to assist people to the upper floors. One the first two days of our inspection there were 17 people living at the service; on the third day of our inspection there were 15 people living at the service.

The registered manager has been registered with the Care Quality Commission since October 2010. 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.

Summary of findings

We previously inspected Germaina House in June 2014. At that inspection we found the service was not meeting all the standards which we inspected. We found that infection control and prevention procedures were not always carried out appropriately. The boiler was in the process of being repaired and was accessible to people who used the service which meant they were at risk of harm. Staff training, supervision and appraisals were not up to date. There were gaps in the records.

At this inspection we found that safeguarding alerts had been recorded and investigated by the registered manager. Not all staff understood their roles and responsibilities when dealing with a potential safeguarding alert. Safeguarding training was not up to date; this meant staff did not have the necessary knowledge and skills to deal with a potential safeguarding alert.

Risk assessments for the day to day running of the service were in place but a fire risk assessment had not been updated regularly. This risk assessment should have been updated each year. This meant that we did not know if the risks to people around fire safety were still relevant. Some people had person specific risk assessments in place however some people did not, for example a person at risk of falls did not have a falls risk assessment in place. This meant the service had not assessed the risks to the person and had not put measures in place to reduce their potential risk of harm.

Fire drills had not been completed; however on the second day of our inspection we saw the registered manager had completed a fire drill with staff. The administration office was cluttered with boxes and paperwork piled on top of one another. This posed a potential health and safety risk to people and staff.

Staff employed at the service did not wear a name badge. Some people did not wear a uniform. This meant that we did not always know if people were employed. We also did not know what people's designated roles were.

Certificates for equipment and for the health and safety of the service were in place.

Some people required the care and support of two staff at all times. There were enough staff on duty throughout the day to provide this. At night we found that the one waking member of night staff could not facilitate this. People told us that their buzzers were not always answered and impacted upon their dignity because they could not always get to the toilet when they needed to.

People told us they needed to wait for the day staff to come on duty before they could get up because there were not enough staff on duty during the night. On the third day when we visited early in the morning we found that although the registered manager had previously acted as a sleeping night staff due to our raising concerns about the staffing levels they had acted as a waking night. We found that they were working as waking night staff and then undertaking the management role during the day.

We also found that despite the registered manager having some mobility difficulties no consideration had been given to either the level of support they may need to provide to people overnight or the risks this might poise. We discussed our concerns at length and the registered manager agreed to provide two waking night staff and not to undertake this role themselves. We confirmed that this change to the rota had occurred.

Each week, a member of staff not trained in medicines worked at night. If people required medicine throughout the night they had to alert the registered manager [sleeping night member of staff]. This meant there was a delay in people receiving their medicine at night if needed.

Good procedures were in place for managing medicines. Only staff who had been trained could handle and distribute medicine to people. Medicine records had been completed and topical cream records provide details about when and where to apply creams.

There were gaps in the provision of infection control and prevention at the service. Infection control training was not up to date, there were not always enough supplies of hand washing equipment available and some floors, vanity units and shelves displayed bare wood which meant they posed a risk to infection prevention and control. We found that the registered manager took action when these concerns were highlighted during our inspection.

There were gaps in supervision and appraisal. Supervision was not carried out regularly [as identified in the service's policy]. We could not be sure about the

Summary of findings

effectiveness of the supervision which staff were receiving. Most staff [18 out of 23] had not received an annual appraisal. This meant staff were not receiving the guidance and support needed to carry out their roles.

Training was not up to date. Care staff did not have person specific training, such as Dementia and Parkinson's Disease or training appropriate to the environment which they worked in, such as Mental Capacity Act and Deprivation of Liberties Safeguards. Staff were not aware of their roles and responsibilities to determine whether a person was capable of making a decision.

People spoke positively about the food and hydration which they received. However there was no choice of meals readily available at mealtimes provided at the service. People were supported to put on weight when needed and staff understood the action they needed to take if people lost weight consistently. We could see that people's general practitioner and a dietician would be involved when needed.

Apprentice staff often worked unsupervised. From our observations, they did not appear to know the people they were caring for.

Consent forms for photographs had been signed but not dated which meant that we did not know if they were relevant. One person had refused a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) certificate to be put in place; however we saw this person had this certificate in their care records. In another person's care records we could see that they had refused an influenza vaccination but records showed this person had been given one. This meant we did not know if this person had consented to this.

The door at the service was locked which meant that people could not leave when they wanted to. People's consent for this had not been sought and a risk assessment had not been carried out. Some people did have a Deprivation of Liberties Safeguard in place; however this locked door had been in place prior to this safeguard. This meant there was a breach to people's human rights.

People gave mixed views about their relationships with the staff team. We could see that staff [who had worked at the home for some time] knew people well and were aware of their individual needs. Staff told us they enjoyed working at the service.

There were significant gaps in the care records. Records were not personalised and reviews did not contain the information needed to provide the most up to date care and support for people Reviews did not always show who had been involved in making decisions about the people they related to.

People's privacy and dignity were not always maintained. We did see staff knocking on people's doors but we also witnessed personal care being given when a door was left open. Equipment needed to support people was not returned to them in a timely manner or was not always accessible to people, for example, commodes taken for cleaning were not returned promptly or were not in the places people needed them to be.

There was a lack of activities taking place in the home and people told us they did not get to go out when they wanted to. We food that some people spent the majority of their time in their own rooms which increased the risk of isolation to people.

A complaints policy was in place and we could see the action which would be taken if a complaint was made. At the time of our inspection nobody had wanted to make a complaint.

The staff team were supportive of one another. They all described feeling 'happy' in their roles at the service. We did see that there was no strong leadership at the service. Roles were not defined which meant that some people carried out tasks outside of their designated roles. Tasks were carried out on an ad-hoc basis which meant some tasks were missed. There were no quality assurance process in place such as audits, surveys or meetings with people, their relatives and staff.

Following our inspection we spoke with the Local Authority Contracts and Commissioning Team to discuss our findings. Following this, we raised a number of safeguarding alerts [which are detailed within the main report].

When we visited on the third day we found that the provider had taken very serious note of the concerns that

Summary of findings

had been raised. They had employed two additional members of staff, one of whom was a very experience senior staff member. We found that this senior member of staff clearly understood the requirements of the regulations and was making very positive changes to the way the service delivered care. They told us that the provider and registered manager had given them full automony to make any changes they deemed necessary.

We found that they had created a new care record format and this was seen to assist staff maintain accurate and up to date information about the people who used the service and their needs.

We found six breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the premises and equipment and records. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires improvement

The service was not consistently safe.

There was not enough staff during the night to provide the care and support people needed. Effective recruitment procedures were in place.

People could not leave the service because the door was locked. People had not been consulted about this or had consented to this.

Good procedures were in place for the management of medicines.

Maintenance was regularly carried out and certificates were up to date for the day to day running of the service. The administrative office was cluttered and posed a potential fire risk.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff supervision, appraisal and training was not up to date. There was a good induction programme in place for new staff.

People received enough nutrition and hydration but there was no evidence of choice. People's weights were monitored regularly and staff were knowledgeable and the procedures they needed to follow if people needed further support maintaining their weight.

Deprivation of Liberties Safeguards procedures had been followed appropriately for people who needed them. Staff lacked understanding about the Mental Capacity Act and Deprivation of Liberties Safeguards and their roles and responsibilities. Records did not always demonstrate evidence of consent.

Is the service caring?

Requires improvement

The service was not consistently caring.

We heard mixed reviews about the staff team. Some people spoke positively about the staff and others thought improvement was needed.

People's privacy and dignity was not always maintained. People's bedrooms were personalised.

Many people spent the majority of the day in their rooms and were at risk of isolation. Regular checks of people were not consistently carried out and people told us staff did not always have time to spend with them.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

There were gaps in peoples care records. Care records were not personalised and did not always contain accurate information. Records were not always written in date order.

There was a lack of activities at the service. People were not able to go out into the community when they wanted to.

A complaints procedure was in place. Staff knew the procedures they needed to follow when dealing with a complaint. Nobody wanted to make a complaint during our inspection.

Is the service well-led?

Inadequate

The service was not well led.

Concerns identified in our previous inspections had not been dealt with prior to our inspection.

There were no quality assurance process in place, such as audits, surveys and meetings for people, their relatives and staff.

There was no clear leadership in the home. There was no visible presence of the registered manager. Tasks were completed on an ad-hoc basis.

Germaina 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.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning officer from the local authority commissioning team about the service.

The provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 16 July 2015 and 20 July 2015. The first day was unannounced which meant the provider did not know we would be visiting. They were informed we would be visiting on the second day of our inspection. The inspection team consisted of one inspector and an expert by experience. This is a person who has personal experience of using or caring for an older adult including people living with a dementia.

During the three days of our inspection we spoke with 17 people who used the service, two relatives and a visiting health professional. We also spoke with the registered manager, two members of the administration team, the handyman, three senior care staff, six carers and two domestic members of staff. We reviewed six care records, staff files and records which related to the running of the service. We also observed the care and support which was given to people who used the service.

Requires improvement

Is the service safe?

Our findings

All staff we spoke with told us there were enough staff on duty during the day to provide care and support to people. One staff member told us, "We get to spend quality time with people." We found that care staff were very busy throughout the day, particularly at mealtimes. We observed occasions where people were left unattended in the lounge areas of the home, for example, during our inspection we observed three periods of up to thirty minutes where people were left. Two apprentice care staff on duty during our inspection were left unsupervised. We could see that they did not know the people they were caring for and there was little interaction from them when sitting with people. The registered manager told us that agency staff were not used and any shortfalls in staffing were covered in-house.

After looking at people's care records we could see that some people required two members of staff to assist them when care and support was given. We spoke with the registered manager about this and they told us that people did not wake during the night. We found people requiring the support of two staff could not receive appropriate care and support during the night [could not be turned as required in their care plan, could not receive personal care or could not get out of bed if they wanted to]. We could see from people's care records that some people were incontinent and some people would have required support being assisted to the toilet or commode. This meant people were at risk of not having their privacy and dignity needs being met. We spoke to a member of night staff and they told us that they could manage on their own when people required support. One staff member told us, "People cannot get up [early on a morning] until the [day] staff come on duty. The registered manager told us "People who require two staff would be in bed before night duty started." One person we spoke with told us, when they press the call button, staff usually respond in a timely manner. But, especially at night "They don't come at all." People we spoke with told us that buzzers were answered during the night but there could be a wait. One person told us, "The buzzers are answered the first two times during the night but not the third time." Following our inspection we raised a safeguarding alert with the local authority.

One member of waking night staff provided care and support to people. The registered manager provided 'sleeping night' cover every night at the service [the registered manager lived in a flat above the service]. We found that on one night per week, one member of staff not trained in medicines provided cover during the night. This meant that people requiring medicines during the night shift had to wait for the waking night staff member to alert the registered manager to come into the service to provide the necessary medicine(s).

When we visited early in the morning we found that although the registered manager had previously acted as a sleeping night staff due to our raising concerns about the staffing levels they had acted as a waking night. We found that they were working as waking night staff and then undertaking the management role during the day.

We also found that despite the registered manager having some mobility difficulties no consideration had been given to either the level of support they may need to provide to people overnight or the risks this might poise. We discussed our concerns at length and the registered manager agreed to provide two waking night staff and not to undertake this role themselves. We confirmed that this change to the rota had occurred.

This meant there was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 (1). There was insufficient suitably qualified staff on night duty to meet the needs of people during the night who required support with personal care and in the event of a fire. Following our inspection we asked the registered manager to increase the number of staff on night study and we raised a safeguarding alert with the local authority.

Hot water temperature checks had been carried out regularly and were within safe temperature limits. Maintenance records were in place and we could see when tasks had been completed.

Records showed weekly fire alarm tests had been carried out. Emergency lighting had been monitored each month. Six monthly fire evacuation simulations had not been carried out since June 2014. We spoke with the management team and asked them to take action to address this. On the second day of our inspection we could see that a fire evacuation had been carried out. A fire risk assessment had not been updated since May 2014. A fire authority visit letter [04/09/14] stated that fire risk assessments should be carried out every year.

Requires improvement

Is the service safe?

We found that the administrative office was cluttered with paperwork, boxes and items which would not be normally located in an administrative office. This meant that there was little space to freely move in the office, items were piled upon one another. This had been raised during our previous inspections and following Redcar and Cleveland local authority visits. We can see that some action had been taken, but this still posed a fire and a health and safety risk.

All of the people we spoke with during our inspection told us that they felt safe living at the service. A relative told us, "My relative is very safe here. I have no concerns. There have been no issues we have needed to raise."

Safeguarding alerts were recorded each month via Redcar and Cleveland Local Authority consideration log which requires the home to complete this monthly. We could see that records had been made when needed and had been completed appropriately. The registered manager had taken appropriate action to investigate safeguarding alerts. Care staff had not received safeguarding training; they were able to give examples about abuse, however they were not all sure about their roles and responsibilities in relation to raising a safeguarding alert and the procedures which they needed to follow. All staff told us they would seek advice from the registered manager. This meant that staff did not have the necessary knowledge and information they needed to deal with potential safeguarding alerts. All staff we spoke with told us they would whistle blow [tell someone] if they needed to. A whistleblowing policy was in place.

The records of the last four staff employed at the service showed that references and identification had been sought prior to commencing work at the service. Staff had a Disclosure and Barring Services (DBS) check prior to working at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

Good procedures were in place for managing people's medicines safely. Appropriate arrangements were in place for ordering, obtaining and checking medicines upon receipt into the home. We looked at the medical administration records (MARs) for four people and found they were up to date. We looked at four records for when required (PRN) medication which is medication which is not routinely given, but is available for people when they need it. Sufficient quantities of medicines were in place for people and were stored safely. A homely remedies policy was in place and referred to specific products which had been given permission by a general practitioner for use in the home. Topical medication administration records (TMAR) were in place and provided information about when, where and how much cream to apply to the person. Body maps had been completed to give staff guidance. Room and fridge temperatures for medication to ensure they were safely kept were in place and were recorded daily. We spoke with the senior carer on duty and could see that they were confident in the procedures which they needed to follow to order, check, administer and dispose of medication safely. People who administered medication were trained to do so and competency checks were in place.

The staff team in place at the home did not wear name badges and there were no photographs on display to say who staff were. This meant that it was difficult to know who staff were or what their designated role was.

Personal Emergency Evacuation Plans (PEEP) for people living at the home were up to date. A PEEP provides staff and emergency workers with the information they need to evacuate people who cannot safely get themselves out of a building unaided during an emergency. All staff we spoke with told us they felt confident in dealing with emergency situations.

Care records for one person showed that this person was at risk of falls, however no risk assessment for falls was in place. Risk assessments were in place for people for things such as pressure sores, weight, mobility, bathing and medicines. A risk assessment was in place for one person who liked to wash the pots after meal times. We could see that the risks of hot water had been adequately assessed.

Certificates required for the safety and security of the building were up to date. There was evidence of damp in the dining room. We highlighted this at our last inspection [June 2014]. The management team told us that repairs to the guttering had been made and the problem was now resolved. However we could see that paint was peeling away from the wall and the wall felt wet when we touched it.

Requires improvement

Is the service safe?

The electrical cupboard was accessible during our inspection. We also found that locked doors [gas boiler cupboard and medicines room] were locked but their keys remained in the locks. We spoke with the management team and a lock was put on the electrical cupboard and keys removed from locks. A bench located next to the pond in the yard area of the home only had one slat of wood on it; this meant that this was unsafe for people to use. We spoke with the management team and they removed this bench straight away. On the first day of our inspection, window restrictors were not in place in two rooms on the first floor. We spoke with the management team and these had been put in place on the second day of our inspection which met the requirements of the Health and Safety Executive [Falls from windows or balconies in health and social care, 2012; Series code HSIS5].

At the last inspection we found that the registered person had not protected people against the risk of infection prevention and control because mattresses and chairs within the home required cleaning and there were no deep cleaning programmes in place. There was a risk of cross infection because people had access to personal hygiene products of other people. There was a lack of understanding about infection control and prevention procedures and infection control training was not up to date. This meant [at the last inspection] there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection infection control training was not up to date for all staff [13 out of 23 staff had completed training]. There was no infection control lead in the home. Not all bins in the home had bin liners in them and hand wash was not available in all rooms where hand washing facilities were located. In one toilet there was no hand wash or paper towels on display, we spoke with the management team about this and they told us this was because of the risks to two people who used the service. We found there were no risk assessments in place which meant that service had not taken appropriate action to monitor the risks to all people living at the service.

In one person's bedroom, their laminate flooring had become worn which meant the flooring posed a risk to the spread of infection because it could not be cleaned effectively [because of the state of disrepair]. Some carpets were stained and in need of cleaning. We found that mattresses and chairs [identified in the last inspection report] were clean. The flooring in two toilets, vanity units and shelving in people's bedrooms had become worn revealing bare wood. This meant they could not be cleaned adequately. We spoke with the management team in the home and on the second day of our inspection new flooring had been laid and vanity units and shelving had been painted to provide a protective and washable seal. We found one bedroom where wall paper had begun to lift away from the wall; on the second day of our inspection we saw that action had been taken to address this.

The laundry had washable floors and walls. There was guidance on display for washing clothing. Hand washing guidance was on display throughout the service, however hand washing competency checks had not been carried out with all staff over the last year as detailed in the service's infection control policy. We spoke with two domestic staff and they detailed the infection control and prevention procedures which they followed. On the second day of inspection, domestic staff had been provided with a uniform which could be washed at a high enough temperature to reduce the risks to infection control within the home.

Requires improvement

Is the service effective?

Our findings

At the last inspections [August 2013 and June 2014] we found that the registered manager had not supported staff to carry out their roles safely because staff training, supervision and appraisals were not up to date. This was in breach of regulation [23] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation [18 (2)] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that some action had been taken, but gaps in this provision still remained. There were gaps in all areas of training at the service for all [23] staff. Some staff had received training in first aid, medicines management, food hygiene, infection control, fire safety, manual handling and diabetes, however there were significant gaps in training for end of life care and dementia. Care staff did not have training in Safeguarding, the Mental Capacity Act or Deprivation of Liberties Safeguards, Health and Safety and Parkinson's Disease. Staff were providing care and support to people without training specific to the needs of people, such as Dementia and Parkinson's Disease. This meant that people could have been put at risk because staff did not have the knowledge they needed to provide the most appropriate care and support to people with specific needs. We found that one member of staff attempted to lift a person in a wheelchair incorrectly [lifting the wheelchair with the person in it] putting them at risk. We intervened to prevent harm to the person. We spoke with the management team about this; we were told this staff member had completed moving and handling training but there was no evidence to support this.

Not all supervision records were available for inspection. The registered manager confirmed that all [23] staff had not received six supervision sessions per year as outlined in the service's policy. Nine supervision records available for inspection showed that staff had received between one and two supervision sessions during the last year. We found supervision sessions were limited to personal requests [such as changes in shifts, training and key worker roles. There was no evidence of information sharing, work management, values and behaviours of the service, team work and employee welfare. There was no evidence of any actions been identified and records had not been signed by the staff they related to, this meant we could not be sure if staff had agreed to the information which had been recorded. Five [out of 23] annual appraisals had been carried out over the last year. Records of these appraisals were not available for inspection.

Apprentice staff worked unsupervised and did not have the knowledge they needed to provide personalised care and support to people. We found apprentice staff providing one to one support with people, for example, we found one apprentice assisting a person to eat. We found that the apprentice struggled with this, particularly when the person displayed behaviours which could challenge. The apprentice was not supervised during this activity.

This meant there was a continued breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 because staff had not been supported with regular training, supervision and appraisals necessary to carry out their role. Following our inspection we raised our concerns about staff supervision and training with the local safeguarding authority.

An induction programme for all new staff employed at the service was in place. This included shadowing experienced staff members, getting to know people who used the service, training and familiarising themselves with policies and procedures at the service.

Some people living at the service had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNARCPR) certificate in place. We could see that the person they related to were involved in the decision making, along with a relative and a health professional. A care plan for one person's stated that they had not wanted a DNAR certificate to be put in place, however there was a certificate in the person's care records. Consent forms for people's next of kin to view their care plans and to take photographs had been signed but not dated. A consent form for an influenza vaccination for one person had been signed by the person to indicate a refusal. These care records showed an influenza vaccination had been administered. This meant that we could not be sure if this person had given their consent.

This meant there was a continued breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 (1) because consent to treatment was not clear.

The daily menu was displayed on the blackboard in the dining room [there were no pictorial menus]. The menu was vague, for example on the first day of our inspection

Requires improvement

Is the service effective?

'chicken' was on the menu for lunch. When we asked the senior carer on duty they told us roast chicken, potatoes and vegetables were being provided for lunch. The menu on display did not reflect this. There was no evidence of choice available on the blackboard or on the four-weekly menus which had been pre-written. People we spoke with confirmed that a choice of meals was not routinely offered and the menu was "repetitive." We spoke to the registered manager about this and they told us that people would be offered an alternative. When we spoke to staff about alternative menu choices we could see that planned alternative choices of menu's had not been considered. Staff told us that people could have soup, but on the day of our inspection no alternative food had been supplied for lunch. This meant that is people did not want what was on offer they would need to wait for something else to be prepared. This meant there was a lack of readily available choices at mealtimes.

This meant there was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (1) (b) (c) because there was a lack of choice at mealtimes. This meant the care provided did not always meet people's needs or reflect their preferences or give them choice.

People we spoke with were very complimentary about food. We were told, "The food is very, very good," And "The food is very good," And "The food is really good," And "We get plenty to eat and drink." We observed people being offered regular drinks and snacks throughout the day and we could see that food was freshly prepared each day by staff. At lunch time we found that there was a delay in people getting their food. We found that three care staff were responsible for cooking and preparing food as well as delivering food to people in the dining room and to people in their own rooms. Staff were knowledgeable about people's dietary preferences and records were in place to support this, however not all records had been fully completed. People had been weighed each month. One staff member told us, "If someone lost weight I could speak with the manager and a referral to a dietician." At the time of our inspection nobody needed the involvement of a dietician and nobody required a food or fluid balance chart to be in place. All care staff knew about the action they could take to increase people's dietary intake if people were losing weight. This included adding ice-cream or cream to food and offering high calorie food.

The internal door of the home [before the external front door] was locked with a key which one member of staff carried with them. The management team told us "This door has always been locked." They confirmed that a risk assessment had not been carried out to have the door permanently locked to examine the potential risks to people. People we spoke with, staff and the management team all confirmed that people's consent had not been sought to keep this door permanently locked. We could see that some people who used the service had an appropriate Deprivation of Liberties Safeguards (DoL'S) in place, however from discussion with the management team we could see that the door had been locked before these safeguards were in place. This meant there was a breach to people's human rights because people who used the service could not leave the home when they wanted to.

This meant there was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2) (a) (b) because the risks to the health and safety of people who used the service had not been appropriately considered.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure the rights of people who may need support to make decisions are protected. Training records showed care staff had not received recent training in the principles of MCA. Care staff did not have a good understanding of these principles, their responsibilities and the procedures which they needed to follow to determine whether a person had capacity to make a decision. Care staff did not understand the potential restrictions which could be placed upon people. Care plans contained assessments of the person's capacity when they were unable to make a decision. Care plans did not detail the efforts which had been made to establish the least restrictive option for people. We found that one care plan stated that the person had capacity but a Deprivation of Liberties Safeguarding (DoL's) had been granted. Records showed the people involved in this decision making process including an independent mental capacity advisor (IMCA). This meant that we could be sure if any decisions made on the person's behalf were done so after consideration of what would be in their best interests.

The Care Quality Commission is required by law to monitor and use the Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe

Requires improvement

Is the service effective?

amounts to continuous supervision and control. The management team were aware of their responsibilities in relation to DoLS [administrators had received training and were responsible for completing records in relation to MCA and DoL's]. At the time of our inspection DoLS had been authorised for four people who used the service.

People had regular access to health professionals and we observed this during our inspection. People we spoke with confirmed this to be the case. One relative told us, "Since my relative has been here, they have never been admitted to hospital. Prior to coming here they had been in hospital a lot." People who used the service had hospital transfer records in place in case they required emergency hospital treatment. This record detailed the person's name, next of kin, current prescribed medicines and allergies. There were also details about the person's health history. This meant that appropriate care and treatment could be given.

Two houses had been adapted to provide accommodation for people using the service. Bedrooms were located on the ground and first floor [accessed via stair lifts]. Access from one side of the house to the other is via the lounge on the ground floor and via one corridor on the first floor. Parts of the service had been adapted, for example, chair lifts and ramps were in place where needed.

Requires improvement

Is the service caring?

Our findings

We found inconsistencies in the service's approach to dignity and privacy. There was no dignity champion in place at the service. During our inspection we could see that some people were up eating breakfast and some people were still asleep. We could see that people were still asleep because their bedroom doors were open. One person told us, "Staff ask whether I want my door left open on a night." On the first day of our inspection we observed one person receiving personal care in their bedroom [their bedroom door had not been closed]. We did observe staff knocking on people's doors before entering. One staff member told us, "We check we are doing what people want by talking to people and understanding their needs." We spoke with one person in their room and they told us they needed to use their commode very quickly at times and had not always been able to reach this in the time they needed to. We spoke to people who used commodes or urine bottles; they told us these were not always emptied during the night before they needed to use them again. From our discussion with people we could see that their dignity was not always maintained. One person told us that staff "play war with me" and say "it's unacceptable." During our discussions with people in their rooms, we noticed that the bowls from the commodes had been removed for cleaning [a clean one had not been provided], one person we spoke with told us, "It can be up to two hours before they are returned. Following our inspection we raised a safeguarding alert with the local authority about this.

In another person's room we found that the call bell was not placed with the person when they were sitting in the chair in their bedroom. This meant the person could not alert staff when they required support. During our inspection, two people were brought into the lounge area and were left in their wheelchairs without their brakes on. These people were not asked if they would like to remain in their wheelchairs. One person received a visitor during our inspection. The staff member spoke to the visitor and suggested they go to the quiet room; the staff member moved the person in their wheelchair without asking their permission to do so.

This meant there was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 (1) because people's dignity had not been maintained.

People spoke positively about the care they received. One person told us, "I'm very grateful for all they are doing for me," and another person told us, It's very pleasant here and they help you. I'm happy." People we spoke with and relatives all spoke positively about the care and support they received from staff at the service. One relative we spoke with told us, "They are well looked after. They are well fed and are putting on weight. This is a good thing, being here has made a huge difference to their well-being." From our observations and from speaking with staff we could see that they enjoyed working at the service. We heard and saw lots of discussion between staff and people who used the service. We heard staff singing with people. Staff had a good rapport with people and knew everybody by name. One staff member told us, "I really enjoy my job. I lark about in the lounge to make people happy."

We heard mixed reviews about the staff team in place at the service, some were described as "friendly and nice" others were described as "dogmatic" and "having to go by their rules." One person told us, "Some staff could be more friendly – come and talk with us. Another person told us, "The staff are very pleasant." People told us, "We're well looked after," And "The staff are fine – excellent." Some people told us that some staff were more approachable than others. Three people told us that "Staff could be more friendly." One person told us, "The staff are very helpful."

One relative told us, "My relative gets up when they want to. They are independent, but staff supervise them. They are good a communicating with us about their care." During our inspection we saw that people could get up later in the morning if they wanted to, but if people wanted to get up early then they had to wait for the morning staff to arrive. People told us they were looked after, one person told us, "Everybody's looking after you." The morning routine appeared very busy at the service, but we could see that people were given the time they needed when care and support was provided. People who were sat in the lounge during this busy time were left unattended. There were no discussions between people. The television was on but was not watched; people sat in silence.

The lounge area of the home was the main access between the two adjoining properties. This meant that staff and visitors had to walk through the lounge. We found that staff did not always acknowledge people when walking past them in the lounge. We observed one person had been left in their wheelchair in the lounge. When they leaned

Requires improvement

Is the service caring?

forward to reach out for something in front of them, we overheard two people tell each other they felt frightened that they would fall out of the chair. Although many people spend their time in lounge we found that staff presence in this area was minimal and people were often left on their own sitting quietly.

Although the service was busy at times, there was a relaxed atmosphere, one staff member told us, "It's very homely here. There is a relaxed environment." Another staff member told us, "I like the family atmosphere here." Staff displayed a caring attitude toward people and demonstrated compassion when needed. The registered manager spoke with genuine concern about people.

We observed that staff would come down to people's level if they were sat down to talk to them and touched people appropriately [whilst maintaining personal and professional boundaries] to offer reassurance.

We looked in people's bedrooms [with their permission] and could see that these contained people's personal belongings. We saw that one person had a budgie in their room and other people had televisions, radios and personal photographs. When we visited one person in their bedroom they were watching the television. We could see that their view of the television was obstructed. This person was not able to get up on their own to move the obstruction and staff had failed to notice this. Whilst we were taking to this person, we removed the obstruction and informed the management team.

We found that people [nine out of 17] spent the day in their rooms and had their meals in their rooms too. Some of these people told us they felt too frail to tackle the stairs and did not feel safe using the stair lift which meant that they chose to stay in their rooms. We found that these people were at risk of isolation. Another person told us they liked to stay in their own room during the day and that one staff member in particular came to see them every day which they stated was "Very good." Some people we spoke with told us they felt lonely at times. We could see communication at times was task driven because staff interacted with people more when they were providing care and support. We found staff did not often have the time to sit with people and chat with them.

On the first day of our inspection there was no information on display about advocacy. An advocate is an independent person who can provide support and advice to people. On the second day of our inspection, the management team had taken action and a poster was on display at the service. They also told us they had been in touch with the local advocacy team and had arranged for leaflets to be delivered to the service.

Requires improvement

Is the service responsive?

Our findings

At the inspections [15/03/2013; 06/08/2013 and 03/06/2014] we identified breaches of regulation [20] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation [17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because accurate records relating to care plans and records relating to the day to day running of the service had not been maintained. At this inspection we could see that the registered provider had taken some action to make improvements however this still did not meet the requirements of the regulation.

Care plans were not always individual to the person they related to or the care needed, for example, a bathing care plan did not detail the support need. A decision making care plan did detail the decisions the person was capable of making. A care plan for constipation did not detail when treatment should be started. A care plan for 'conditions of the skin' referred to incontinence, diet and fluid intake and social activities. There were gaps in reviews and we found they lacked detail, for example a review of a person's mobility stated 'improvement' but no further information and a review of 'social and emotional health' recorded "No signs of emotional health." This information did not provide the detail needed to ensure the most appropriate support was in place for the person it related to Reviews did not consistently record if the person they related to [and if appropriate their families] had been involved. There was no evidence of people's relatives being invited to their reviews.

This meant there was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (1) (b) (c) because care records were not person-centred.

Information in a best wishes care plan had been crossed out [no date or signature] in one person's care records; this meant we did not know if this information was still relevant. No guidance information had been recorded. A consent form was in place for staff to assist one person to make decisions, but no guidance was in place about what type of decisions this person may need assistance with. Daily records and handover records were repetitive and contained comments such as "fine, ate and drank well" were frequently recorded. District nursing records had been recorded in the section for an independent mental capacity advisor; this meant that these notes could be missed by care staff.

A risk assessment for skin breakdown was in place but a care plan was not. No information was provided about skin care or if body turns were required to alleviate pressure to sores. We found that risk assessments were in place but their associated care plans were not. A risk assessment for personal care due to injury did not detail the injury and the assistance needed. Turn charts for one person had not been completed every two hours. This meant that we did not know if the person the chart related to had been moved regularly to relieve pressure from the affected area. We could see that this person required the support of two members of staff to be turned; records showed that this person was repositioned during the night when only one member of staff was on duty. This meant both the person and the staff member were not safe.

Activity records were not completed each day and contained limited information, for example, records contained information about visits from health professionals, care plan reviews and people being weighed. We found there was a lack of knowledge and understanding about what an activity was and what should be recorded in people's activity records. Activities records were not completed each day and were not contemporaneous.

Hospital transfer records contained limited information about the person, for example, the record did not state the reasons why a person may have a DoL's in place. There was no information about what the person could do for themselves and if they had any difficulties with their sight, hearing or mobility. One person's record stated they had decreased mobility but no explanation was provided about what this meant. Records were not consistent, for example one record had the person's current height and weight, and another record did not.

Laundry room cleaning records were not completed every day. Cleaning records listed tasks which needed to be completed, however tasks did not specify their frequency. Records were not fully completed each day. There were no deep cleaning records. A commode cleaning record for July had only been completed for five days. Weekly cleaning records of both fridges in the home had not been

Requires improvement

Is the service responsive?

completed each week. Maintenance records showed that tasks had been completed, however we found that one job which had been signed as being completed had not been carried out at all.

We looked at the induction records of the last four staff employed at the service. Two members of staff signed their induction record which stated they had received moving and handling training before their actual training. One member of staff signed their induction record to show they had received this training. When we checked the training records, we could see that this staff member had not received this training.

Not all policies at the home had been reviewed regularly. We found that policies such as infection control, fire safety, first aid, recruitment and moving and handling had not been reviewed since 2004. We found duplicate policies in place, old policies had not been removed once an more updated policy had been put in place, for example a complaints policy [dated March 2007] remained in the same folder as a more updated policy [dated October 2014].

This meant there was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 (1) because accurate, complete and contemporaneous records were not carried out for people using the service and the running of the service.

Pre-admission assessments had been completed for people prior to moving into the service. This meant that the service had the information they needed to ensure the most appropriate care and support was in place for people when moving into the service

A complaints policy and procedure were in place. All staff we spoke with were confident about the action they needed to take should a complaint arise. At the time of our inspection no complaints had been received into the home and nobody we spoke with wanted to raise a complaint.

An activities timetable was available [but not on display] at the service. During our inspection we did not find any activities taking place with people. One staff member told us, “We do not have time to carry out activities with people because people’s care needs have increased.” Throughout our two day inspection we found people sat in the lounge, often the television was on but people were not watching it. One person we spoke with told us, “Nothing happens; you just look at four walls.” Most people we spoke with could not recall any activities taking place recently. When asked about activities, person told us, “I’ve never seen any.” A relative told us, “I once saw a game of bingo taking place.” We were concerned about the lack of activity taking place at the service and spoke to the management team about this. Two staff members started an activity with people however this was stopped [and not recommenced] once refreshments arrived.

We could see books, music records and boxes of activities in the communal areas of the service, however we did not see them utilised. Newspapers were delivered to the home and people had access to a hairdresser. One staff member told us, “I take people out sometimes. We go to Coatham for afternoon tea or go to the local church.” Many people we spoke with told us that they rarely went out of the home and described feeling sad about this. People also told us that they did not know when they might be able to go out next. People told us that if they went out of the home, this was usually with their relatives or visitors and not with staff from the home.

There was outside space at the home with a pond and seating areas. We found that this area was used by staff as a smoking area. People we spoke with told us that they rarely went into this outside area.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in place [registered October 2010] and had been at the service prior to this registration.People who used the service knew who the registered manager was and felt able to approach them if they needed to, however we received mixed reviews about the visible presence of the manager. One person told us, "I hardly ever speak with the manager," and another person told us, "I never see the manager."

One relative we spoke with told us, "The staff are very approachable. Everyone is lovely, I can't find fault with any of them.They are lovely with people." All staff spoke positively about one another and felt able to rely on each other. One staff member told us, "There are a nice bunch of staff here." We could see that staff worked together to provide care and support for people. We could see that specific tasks were not allocated and carried out on an ad-hoc basis when meant that some things were missed or not picked up. All staff told us that they felt able to approach the registered manager and had a good relationship with them.

The home lacked clear leadership. We observed one of the administrators carrying out the day to day responsibilities of the home. When we spoke with the registered manager about this, they referred to this person as their business partner; all staff referred to this administrator 'being in charge along with the registered manager.' We found that duties were not always allocated according to designated role, for example, another administrator carried out care plan reviews with people, not care staff. The handyman was responsible for administrative and caring duties. Tasks relating to the day to day running of the home were carried out on an ad-hoc basis; this meant that monitoring was not in place to check the quality of the service. The management team confirmed that audits were not carried out. Audits would have highlights gaps in the records and out of date fire risk assessment [highlighted in the 'safe' and 'responsive' sections of this report]. There was no evidence of any internal monitoring procedures in place which would have detailed changes the service planned to make to improve the overall quality. Accidents and incidents had been recorded regularly and provided appropriate detail, however there was no analysis of these incidents and no identification of any patterns or trends which could assist the service to take action to put preventative measures in place to minimise the risks to other people at the service.

There was no evidence of any lessons being learned or sharing of good practices in the service. Principals of good quality assurance were not understood.

Many of the concerns identified throughout this report have been highlighted previously during our inspections and by Redcar and Cleveland Local Authority. Whilst there is some evidence that the service have made some changes, these have not been to the standard expected. We found that the service made some changes following the first day of our inspection, however these concerns raised [infection control and accessible rooms and cupboards] were in place prior to our inspection and had not been picked up or responded to prior to our inspection.

When we visited on the third day we found that the provider had taken very serious note of the concerns that had been raised. They had employed two additional members of staff, one of whom was a very experience senior staff member. We found that this senior member of staff clearly understood the requirements of the regulations and was making very positive changes to the way the service delivered care. They told us that the provider and registered manager had given them full autonomy to make any changes they deemed necessary. We found that they had created a new care record format and this was seen to assist staff maintain accurate and up to date information about the people who used the service and their needs.

The management team confirmed that meetings for people who used the service, their relatives and staff were not carried out.The registered manager told us that some information was passed on verbally however we could not be sure that everybody was given access to the same information. Surveys had not been carried out to monitor the overall service which people who used the service received.

This meant there was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 (1) because systems to monitor the quality of the service were not in place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Appropriate care could not be given safety during the night and people could not get up before day staff came on duty if they required the support of two staff. There was a lack of choice at mealtimes. Care records were not person-centred. Regulation 9 (1) (b) (c): Person-Centred Care.

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Dignity and privacy were not consistency maintained when care and support was given to people. Regulation 10 (1): Dignity and Respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There were inconsistencies with consent in people's care records and staff did not always seek people's consent before care and support was given. Regulation 11 (1): Need for Consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People could not leave the home when they wished because the door was locked. People's opinions or

This section is primarily information for the provider

Action we have told the provider to take

consent had not been sought about this. A fire risk assessment had not been regularly carried out. The administrative office posed a fire risk. Regulation 12 (2) (a) (d): Safe Care and Treatment.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Audits, surveys and meetings for people, their relatives and staff were not carried out. Records were not accurate, completed consistently or contemporaneously. Regulation 17 (1) Good Governance.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was insufficient people on night duty.

The enforcement action we took:
A warning notice was issued.