Forward Care (Residential) Limited

Hill Farm

Inspection report

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Date of inspection visit: 09 and 15 June 2015
Date of publication: 02/09/2015

Ratings

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

Overall summary

The inspection was carried out on 9 June and 15 June 2015. Our inspection was unannounced. This was a focussed inspection to follow up on actions we had asked the provider to take to improve the service people received and to follow up on concerns and information that we had received since our last inspection.

Hill Farm is located on the outskirts of Sittingbourne and staff provide care and support for up to nine people who have a range of physical disabilities and learning disabilities. People had sensory impairments, epilepsy, limited mobility and difficulties communicating. Accommodation is set out over two floors with lift access to the first floor. On the day of our inspection there were eight people living at the home, one of whom was on holiday on the first day of our inspection.

Hill Farm had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run.

At our previous inspection on 22 December 2014, we found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 1 April 2015. We took enforcement action and required the provider to make improvements. We issued one warning notice in relation to records. We found a further three breaches of regulations. We asked the provider to take action in relation to person centred care, obtaining consent and quality assurance.

The provider sent us an action plan on 20 April 2015 but did not provide timescales by which the regulations would be met.

At this inspection, we found that some minor improvements had been made but the provider had not completed all the actions they told us they would take. In particular, they had not met the requirements of the warning notice we issued at our last inspection. As a result, they were breaching regulations relating to fundamental standards of care.

There were not enough staff deployed to ensure that people were protected from the risk of abuse or harm, one person suffered an injury when they were alone. Staff did not know how the person had injured themselves.

Accident and incidents were not always thoroughly monitored, investigated and reported appropriately. The registered managed had not notified the local authorities safeguarding team about appropriate incidents.

Risk assessments lacked detail and did not give staff guidance about any action staff needed to take to make sure people were protected from harm. Risk assessments had not been reviewed and updated following incidents. Personal emergency evacuation plans did not fully detail people's actions when the fire alarm sounded.

Dried food had been stored inappropriately in the cellar. Action had not been taken since our last inspection. Fridge and freezer temperatures had been recorded but appropriate action had not been taken when the temperatures fell outside normal parameters.

Medicines administered were not adequately recorded. Entries on the Medicines Administration Records (MAR) did not correspond with the prescription and stock balances did not tally with the amount of medicines received and the amount of medicines given.

Staff and the registered manager showed they had limited understanding of the Mental Capacity Act 2005 (MCA). People's capacity to make their own decisions had not been assessed in line with the MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority and had been approved. However, some of the authorisations required the provider to complete actions. These actions had not been completed.

The training staff received did not give them the skills to support people effectively. For example, managing behaviour that other people find challenging gave staff an overview only. The registered manager had developed each person's behaviour guidelines without support and guidance from trained professionals such as psychologists or other health professionals.

Dietary advice given from professionals had not been followed to help a person lose weight.

Staff did not always treat people with dignity and respect. Staff did not always interact well with people.

People and their relatives were not involved in planning their care. There was no evidence to show that people had been included in developing activity plans. People were not supported to do tasks to encourage and develop their independence.

People were at risk of social isolation, they had limited contact with the local community and relatives were not free to visit the home when they wanted to, restricting people's right to a family life.

People did not have activities planned to meet their individual needs. Staff told us they didn't know what to do with people and they lacked information about what was available in the local community. Activity plans contained activities that the person was known not to like.

Summary of findings

Policies and procedures were not relevant to the service. The social contact policy which stated that the home had open days, fetes and that people could read papers and magazines daily. However, the registered manager confirmed that these things did not happen and were not relevant to the service.

People's views were not formally recorded or gathered and feedback from relatives had not been acted on.

Records relating to people's care had not been completed effectively which meant that key information about events and incidents had not been recorded. There were gaps in records.

The provider had not assessed the quality of the service and therefore failed to identify where improvements could be made and act on these. The provider was not aware of the quality concerns within the service and had not identified the issues that we found during the inspection. The registered manager told us that they had little support from the provider and did not receive formal supervision. There was a lack of leadership in the home.

The vision and values of the service had not been effectively implemented or shared with the staff team.

The provider and registered manager were not aware of their responsibilities with regards to notifying the appropriate authorities of important events. They had not notified CQC about, Deprivation of Liberty Safeguards (DoLS) authorisations.

People had access to drinks when they needed them. Staff understood how people communicated that they were hungry and thirsty.

People were supported and helped to maintain their health and to access health services when they needed them.

People were relaxed and their facial expressions indicated that they were happy. Relatives told us that staff were caring and kind towards their family members.

At other times during our inspection staff stopped what they were doing and assisted people when they identified they needed help. People's privacy was respected. Staff supported people with their personal care behind closed doors. Personal records were stored securely.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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?

Inadequate

The service was not safe

People were not protected from abuse or the risk of abuse. The registered manager and staff were not aware of their roles and responsibilities in relation to safeguarding people.

There were not always enough staff deployed in the home to meet people's needs.

Risks to people's safety and welfare were not always managed to make sure they were protected from harm.

People did not consistently receive their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

Training in people's specific needs had not been completed. Most staff had the essential training and updates required.

Staff and the registered manager had limited understanding in relation to the Mental Capacity Act 2005. The provider understood how to implement Deprivation of Liberty Safeguards.

People were offered a choice of drinks and food. However, dietary advice given by professionals was not always followed.

People were supported effectively with their health care needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

People or their representatives were not always involved in planning their care.

People were not always treated with dignity and respect. However, the staff respected people's privacy.

People's right to a family life was restricted because their relatives were restricted from visiting them.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People were not always provided with personalised care and did not have access to activities to meet their needs.

People's views were not formally recorded or gathered and feedback from relatives had not always been acted on.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The provider had not assessed the quality of the service and therefore failed to identify where improvements could be made. The provider was not aware of the quality concerns within the service.

The provider and registered manager were not aware of their responsibilities. They had not notified CQC about important events.

Records relating to people's care had not been completed effectively. There were gaps in records.

Hill Farm

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 9 & 15 June 2015. Our inspection was unannounced. This was a focussed inspection to follow up on actions we had asked the provider to take to improve the service people received and also following concerns we had received since the last inspection.

The inspection team included two inspectors and an expert-by-experience who had personal experience of caring for family members with a learning disability. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including the provider's action plan, the provider's information return (PIR) which we received on 28 May 2015, information from the local authority, information from whistle blowers and our last report.

During our inspection we observed care in communal areas; we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We examined records including staff rotas; management records and care records for four people. We spoke with three people, four care staff, the registered manager and the provider. We also spoke with the local authority safeguarding team, a nurse assessor and a local authority care manager. The expert-by-experience also contacted six relatives by telephone.

Inadequate

Is the service safe?

Our findings

At our last inspection on 22 December 2014, we identified breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough staff to meet people's assessed needs. We asked the provider to take action to make improvements to their staffing deployment procedures. The provider sent us an action plan but did not provide timescales by which the regulations would be met.

At this inspection we found that improvements had not been made.

People were unable to verbally tell us about their experiences. We observed people were relaxed around the staff and in their own home. One person who was on a holiday with staff support rang up several times during the inspection to check in with staff, we heard staff reassure the person and wish them happy holidays.

One relative who visited their family member once a year told us that the home was, "Very well staffed". Two relatives told us that there was a high turnover of staff and high use of agency staff. All relatives we spoke with said their family members were safe.

There was not enough staff deployed to make sure that people were protected from harm or received the individual care they needed. There were seven staff on shift. We observed those people who had been assessed as requiring one to one staffing for twelve hours a day received this. However, one person received support for six hours per day. The shift planner in place evidenced that the person received six hours of one to one support per day. One of these hours was allocated to support at lunch time and one was allocated to dinner time. We observed people receiving support over lunch time and saw this person received 25 minutes of support with this. During the evening (at 19:10 hours) we found the same person sitting on the floor of the lift. The person had sustained an injury to their face, and they were agitated and upset. Staff did not know how long the person had been there. We asked the registered manager to investigate and we reported this to the local authority as a safeguarding concern.

During a senior staff meeting on the 15 June 2015 there was a discussion about the providers plans to reduce the staffing levels as the home had a vacant room. We were concerned about this discussion as it was clear that the staffing levels had not been assessed based on people's needs and instead they were based on the number of people in the home. Staff at the meeting challenged this with the registered manager and provided information to evidence that the current level of staffing was suitable to meet the eight people's needs.

The failure to provide care and support to meet peoples assessed care needs was a breach of Regulation 9 (1) (a) (b) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accident and incident forms showed staff had recorded and reported incidents where people had been challenging and had resulted in injury to others. The forms completed varied and it appeared there was no set format. There were some which were incidents between people but they had not been reported to social services. For example one incident report completed on 22 February 2015 detailed that the incident involved injury to others, challenging behaviours, aggressive behaviours. The registered managed told us they checked the forms for accuracy when they had been completed and submitted by staff. They said the incidents and accidents would only be escalated if there was a serious incident between two people. We asked if the incident on the 22 February 2015 had been reported to the local authorities safeguarding team. The registered manager said that "Didn't think that it warranted raising a safeguarding". This meant that physical abuse had not been reported to the appropriate authority and had not been reported to the Care Quality Commission.

The registered manager had not followed their own policy and procedure for informing the local authority safeguarding team which meant the local authority was not aware of all incidents that happened within the home. This was despite all the staff having access to the local authorities safeguarding adult's policy, protocols and guidance, which was in date and the provider, had a detailed adult protection policy in place.

This failure to safeguard people from abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person's care plan contained individual risk assessments in which risks to their safety were identified such as falls, mobility, diet, anxiety, community trips, health

and safety. The risk assessments had been revised in 2015. The risk assessments lacked detail and did not give staff guidance about any action staff needed to take to make sure people were protected from harm. Following an incident on the 9 June 2015 a risk assessment had been put together by the registered manager to assess the risks to a person. This risk assessment did not detail what action staff should take such as whether the person needed to be escorted or supported when using the lift. The risk assessment described that there was a risk. The registered manager explained that staff would support the person in the lift when the person was not showing signs of behaviours that could injure themselves or others. This had not been detailed within the risk assessment.

Fire safety systems were in place and each person had a personal emergency evacuation plan (PEEP) to make sure staff and others knew how to evacuate them safely in the event of a fire. The PEEPS had been revised and reviewed in June 2015. PEEPS were individualised to each person. They showed that one person would need to be led to a place of safety as they had a visual impairment. At our last inspection staff told us that one person became distressed and anxious when the fire alarm sounded. They explained that this person was known to lock themselves in their bedroom and ignore the fire alarm. Their PEEP did not detail that this could happen and did not detail what staff should do in this situation. Records evidenced that fire alarms had been tested regularly and that there had been fire drills. One staff member told us that the person was reluctant to evacuate the building.

This failure to ensure that risk assessments were suitable and sufficient to keep people safe from harm was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Fridge and freezer temperatures had been recorded but not appropriately monitored. Many temperature readings were above the required temperature for storing food. For example, some fridge readings exceeded 12 degrees Celsius and some freezer readings exceeded minus 30 degrees Celsius, which are outside of the safe temperature ranges for storing food. We spoke with the registered manager about this and they told us that they would investigate whether there was a problem with the fridges and freezers or whether there was a problem with the thermometer. The registered manager did not provide us feedback about the investigation. This meant that the registered manager could not be confident that food had been stored within safe temperatures.

The failure to properly maintain equipment was a breach of Regulation 15 (1) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The fridges and freezers were clean, appropriately stocked and food was in date and labelled when it was opened. Dried food had been stored on the same shelf as chemicals in the cellar. We had reported this concern previously in April 2014. We checked the cellar of the building as we had received some concerns from staff before our inspection. We found the cellar area to be locked to prevent unauthorised people from entering. The cellar was dry and we saw that a pump was fitted to the floor to remove water. The provider explained that during heavy rainfall the cellar would sometimes let in water. In these situations the pump was activated. Electrical equipment such as fridges and freezers within the cellar were situated on pallets to ensure that they were not affected by water.

This failure to store food safely to protect people from cross contamination was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive their medicines as prescribed and 'as required'. We looked at the medicines administration records (MAR charts) to check that people had been given their medicines as prescribed. The charts showed that medicines were given as prescribed and only as when required. For example, the MARs showed that people had indicated that they were in pain, which was the reason for them having Paracetamol on an as required basis. The records showed that people were asked before the medicines were given.

However, we found a number of entries on the MAR charts that did not correspond with the prescription. For example, one person was prescribed to take Macrogel Compound NPF Oral Powder, the MAR chart stated that the prescription was 'Take 2 to 4 sachets per day as directed' however the MAR chart evidenced that staff had been administering one sachet per day. One person's Macrogel Compound NPF Oral Powder stock did not balance against the amount received and the amount that had been administered. Another person's Macrogel Compound NPF

Inadequate

Is the service safe?

Oral Powder had not been given as stated on the MAR chart, however, notes on this MAR chart evidenced that the person had been constipated so another dose had been given, which meant on 01 June 2015, the person had been administered the correct amount of Macrogel Compound NPF Oral Powder. The registered manager had not appropriately monitored medicines. Another person's prescribed creams had not been signed for as given on 26 May 2015. Body maps were in place to show staff where to apply creams on people's bodies. One person's body map showed that staff should apply Aqueous cream all over the body twice a day. The MAR chart stated that the person should have Aqueous cream when required. The MAR chart had not been signed so it was not possible to know if the person had been having the cream daily or not. Staff told us that the cream had been administered.

The failure to properly manage medicines was a breach of Regulation 12 (1) (2) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection on 22 December 2014, we identified breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's capacity had not been assessed following the principles of the Mental Capacity Act 2005 (MCA), staff showed limited understanding of the MCA. We asked the provider to take action to make improvements. The provider sent us an action plan but did not provide timescales by which the regulations would be met.

At this inspection we found that improvements had not been made.

People were unable to verbally tell us about their experiences. We observed that people were supported to eat and drink at meal times to ensure they had enough to eat and drink. Interaction at meal times was not consistent for everyone. One person was supported with their lunch with very little communication from the staff member, whilst other people had more of a positive experience.

Relatives told us that their family members received effective support with their healthcare. Two relatives told us that staff informed them if there was a change in medication or that their family member had been to see the doctor or the hospital. Two relatives told us that they had been involved in best interest's decisions.

The provider had not made improvements to Mental Capacity Act 2005 assessments. Staff and the registered manager showed they had limited understanding of the Mental Capacity Act 2005 (MCA). One staff member told us that if they needed to make a best interest decision they would go to the registered manager. Training records showed that 11 out of 12 care staff had completed MCA training. Mental capacity assessments had also been carried out for a number of decisions, which included managing personal finances and receiving private mail. Capacity had not been assessed in line with the MCA, and the overarching theme of assumption of capacity. Capacity assessments showed that people's capacity had been assessed as lacking due to their diagnosis of learning disability. One person's capacity information stated 'I have some verbal communication and able to tell you yes or no or what I'm not happy with'. It then stated 'Staff must act in my best interest as I have no mental capacity to make a decision'. The registered manager did not understand that statements of this nature do not meet the principles of the Mental Capacity Act.

Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority. The local authority assessors had been to visit people in the home and had approved all of these. Some of the authorisations required the provider to complete actions which included, updating care plans to comply with the MCA assessments, to comply with the MCA and be decision specific. The local authority also challenged generic statements in documentation stating that people had no capacity to consent to any decisions. These actions had not been completed.

The failure to act in accordance with the Mental Capacity Act (2005) is a breach of Regulation 11 (1) (2) (3) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent time talking to staff and the registered manager about the training they had received. All staff had attended NAPPI training. NAPPI is 'Non-Abusive Psychological and Physical Intervention' which gives staff skills to assess, prevent and manage behaviour that may be challenging to others. However, staff told us that this training gave them a broad overview of working with people who can become challenging. The training did not give them specific guidance and support to enable them to safely work with people who live at Hill Farm. One member of staff told us, "Didn't find it useful as they couldn't apply some things to service users here". They went on to say that each person has behaviour guidelines in their care plan, they would follow these. Another member of staff told us that they had not done specialist training to support them providing care for a person with the diagnosis of Pica. Pica is the eating of objects which are not suitable to be eaten.

This failure to provide training and support for staff relating to people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they had developed each person's behaviour guidelines. They explained that they had done this on their own without support and

guidance from trained professionals such as psychologists or other health professionals. The registered manager explained that they had put the guidance together based on their knowledge of people.

This failure to discuss people's care, support and treatment with a competent health care professional was a breach of Regulation 9 (3) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The cook had left the home since our last inspection. Additional care staff were scheduled on a daily basis to work in the kitchen to prepare meals. The registered manager explained that they had recruited a new cook and that they were carrying out employment checks before they were able to start.

One person's care records evidenced that they were overweight and required a low calorie, low fat, low sugar diet. The person had been supported to see a dietician. Advice from the dietician included offering the person meals on smaller plates and staff to complete a food diary. We observed the person at lunch time during our inspection. They were given their meals on the same size plate as other people. They were given burgers in a bun with salad for their lunch. They showed that they enjoyed the burgers and said "Nice burgers". The person's weight records evidenced that they had put on four pounds in weight between April and May 2015. The food diary did not list all meals eaten, there were missed entries and gaps.

This meant that the person was not supported appropriately to have suitable food to meet their assessed needs and did not follow specialist advice. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to drinks when they needed them. Staff regularly offered people hot and cold drinks during the inspection. Staff understood how people communicated they were thirsty. One staff member told us that one person "Taps their lip when they are thirsty". At meal times, jugs of fruit squash were available on each table and staff assisted people to refill their cups and ensured they kept adequately hydrated especially during the hot weather.

The menu evidenced that people had a choice of food. On the first day of our inspection there was no choice of food at dinner time. The care staff allocated to cook on that day explained that this was because meat had not been taken out of the freezer and defrosted in time. They explained that if someone didn't want what had been cooked that they would be able to make them an alternative hot meal or a sandwich if they wanted it. Staff prompted people to eat the healthier parts of the meal such as salad. The staff tried different ways to encourage this, which included offering mayonnaise and other sauces. Staff respected people's decision not to eat this.

We looked at whether people received medical assistance when they needed it. A nurse assessor told us, "I think the service is very proactive in their approach to changing need and act in a timely fashion". People were supported and helped to maintain their health and to access health services when they needed them. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff spent time with people to identify what the problem was and sought medical advice from the GP when required. Handover records evidenced that the night staff were concerned about a rash on one person's legs on the 08 June 2015. The senior support worker on shift contacted the GP on the 09 June 2015 whilst we were in the home. The GP visited the person on the same day and prescribed the person medicines. Records evidenced that staff had contacted the GP, social services and relatives when necessary. People had been supported to attend appointments with their GP for medicines reviews, flu jabs and to attend hospital appointments when required.

Staff received regular supervision from their manager, during which they and their manager discussed their performance in the role, training completed and future development needs. Staff felt they received good support from the manager in order to carry out their roles. We had received information before we inspected the home about staff not completing inductions when they were new. New staff had received an induction, records showed that this was completed by ticking off areas covered such reading policies and procedures. There was nothing to show that new staff had been monitored and assessed in their induction period following good practice guidelines provided by Skills for Care.

Requires improvement

Is the service caring?

Our findings

At our last inspection on 22 December 2014, we identified breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's records were not always stored confidentially. We served a warning notice which required the provider to be compliant by 8 February 2015. We also found that staff did not always treat people with kindness and compassion.

At this inspection we found that improvements had not been made.

People were unable to verbally tell us about their experiences. We observed that people were relaxed and their facial expressions indicated that they were happy. One person smiled when asked if they had been out in the community to a fast food restaurant, they also pointed to the bus. Another person shrieked in delight and was smiling when staff interacted with him and talked about going out. A local authority care manager told us that they had recently reviewed one person who they had known for many years, "He had never looked so well, settled and groomed and his bedroom was very much personalised".

Relatives told us that staff were caring and kind towards their family members. Two relatives said when they visited their family members; they met with them in a room not shared by other people which meant that they had private time with their family member.

At several points in the day we observed staff members not interacting well with people. One example of this was during the morning, a person was sitting in the lounge area, a staff member was in the lounge with the person, and they did not talk or interact with the person. We spoke with the senior support worker about this, who went in to the lounge and reminded the staff member about interaction. The senior support worker gave the staff member some ideas for interaction such as "Why don't you go through some photos". Another example of this was a person went into the office to take their medication. A staff member told us that they had taken the person to a café the week before however the person had been unwell whilst out. The staff member spoke about this in front of the person and didn't engage them in the conversation or ask them if it was ok to talk about this. This did not show that people were respected and treated with kindness and compassion.

During the seniors meeting held on the 15 June 2015, the registered manager, team leader and seniors discussed that some agency workers had been seen using their mobile telephones when on duty and there had been concerns about staff members talking to each other in a foreign language. The registered manager asked all of the senior staff to challenge this type of behaviour as it was not acceptable. This evidenced that there had been other concerns and issues in relation to treating people with dignity and respect.

Three relatives told us that they couldn't visit their family member when they wanted. They explained that they had to make an appointment to visit. One of these relatives arrived at the home and was told, "You can't come in". One member of staff told us that "Families can come whenever they like but they can't just turn up". Two relatives confirmed that their family member had been supported by staff to visit them. The provider's 'Visitors policy' stated that visiting times were restricted to 10.00 to 12.00 and 14.00 to 17.00. We questioned the registered manager about this, they explained that the home wanted to protect meal times for people and that "Families and visitors are not restricted in the evenings at all". This did not tally with the information families had given to us. Relatives had been asked for feedback about the service in December 2014. Comments from the relatives included that they would like to see their family member other than at reviews. The registered manager had not followed up this concern, feedback from relatives gained before and during the inspection evidenced that they had limited contact with their family members. This meant that people were socially isolated and their human rights to a family life were not respected.

At other times during our inspection staff stopped what they were doing and assisted people when they identified they needed help. For example, one person tapped the cupboard in the dining room, staff asked if the person was hungry and opened up the cupboard. They asked the person what they wanted and the person tapped a box of cereal. The staff member checked whether the person wanted that cereal and gave them other options of food kept in the cupboard. The staff member then went and got some milk and a bowl so that the person could have their cereal. The person was not able to independently get their own cereal as the cupboard where it was kept was locked. People were not supported to do tasks to encourage and

Requires improvement

Is the service caring?

develop their independence. The kitchen was not accessible to people and staff carried out the cooking, cleaning, laundry, running of baths and emptying of rubbish bins.

The examples above show that the provider has failed to treat people with kindness, compassion, dignity and respect. The provider has failed to support people to maintain relationships that are important to them and failed to ensure that people have autonomy and independence. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff respected people's privacy. Staff detailed that when they supported people with their personal care in the bathrooms they ensured the bathroom doors were closed. People's care records were treated confidentially. Personal records were stored securely in lockable filing cabinets in the office to make sure they were accessible to staff.

People and their relatives were not involved in planning their care. There was no evidence to show that people had been included in developing activity plans. People were not able to verbalise their wishes but other ways of including people and involving them had not been explored, such as the use of pictures, objects of reference, sign and trying new things. This meant that care plans had been developed by staff in isolation, some care documents were not person centred and had been cut and pasted from other people's documents. For example, one person's records referred to them as a he, when the person was she.

Inadequate

Is the service responsive?

Our findings

At our last inspection on 22 December 2014 we made a recommendation to the provider about ensuring people were supported to engage in meaningful activities. Activities were not planned to meet people's individual needs. People's views were not formally recorded or gathered.

At this inspection we found that improvements had not been made.

There was no structure to people's day. Staff told us they didn't know what to do with people and they lacked information about what was available in the local community. People had activity planners in place which were not person centred. The planners contained activities that the person was known not to like.

Some people were supported to go out into the community. Records showed that they had been for a walk or a drive and had a drink or food. We observed the senior staff meeting on the 15 June 2015. Those present discussed activities which could be arranged for people who live in the home. These activities mainly consisted of trips out, which included trips to the zoo. One member of staff told us on the 09 June 2015 that some people were scared of animals and the zoo trips were not always successful, this was not discussed or explored in the meeting.

Another person's activity records showed that they participated in water therapy. Staff confirmed that this consisted of the person having a bath and playing with bath toys such as water guns and toys. People did not have adequate opportunities to develop their social network and meet other people in their local community. People did not attend events, discos, and clubs outside of the home. Staff told us that they had never known people to go out and participate in activities in the evenings. The provider had a social contact policy which stated that the home had open days, fetes and that people could read papers and magazines daily. This conflicted with what we had read about people in their care files and observed. The registered manager told us that these things do not happen. This meant that activities were not person centred.

People were unable to verbally tell us about their experiences. We observed that some people were not supported to be active members of their community. One person's day consisted of walking around the small garden and using the swing. They had not been supported to leave the premises for a long time. They were socially isolated. We noted that the atmosphere in the home was generally calm and relaxed and people appeared to be happy.

One relative told us that they had been involved in support planning and their family member was out every day doing activities such as "Walks, swimming, restaurants and art therapy". Another relative said, "They [staff] went through the care plan with me". They also said their family member did activities such as "Nails, art, aromatherapy, music and out in the mini-bus". Three other relatives told us that their family members had limited opportunities, had nothing much to do at all and one relative told us that their family member was "Housebound".

The consent policy stated that people or their representatives were always asked to sign their plan of care. The care plans and care documents we viewed did not evidence this. We spoke with the registered manager about this and they told us that this was not done and "Families used to have a copy of the care plan but this isn't done". This meant that people and their representatives had not been included and involved in planning care and support.

Through our observations, what relatives and staff told us the provider has failed to provide activities and stimulation for people in order to meet their individual needs. They also failed to involve and include relatives when planning people's care. This was a breach of regulation of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meetings had not taken place using different methods to engage people. Although an advocate was working with one person in the home this was on request of social services to support the person with a specific piece of work. The registered manager told us that staff who were key workers completed a monthly form which is feedback from the person. A key worker is a named staff member who is allocated to work with a person. The monthly feedback forms we viewed, listed what had happened in the person's life within the last month such as, whether the person had participated in activities and whether the persons health had deteriorated. It gathered the feedback from staff about the person but not feedback from the person. This meant people's views and feedback had not been sought.

Inadequate

Is the service responsive?

We looked at completed relatives questionnaires which had been received in December 2014. We had seen most of these at our last inspection. One survey that had been received after our last inspection gave mixed feedback. The relative had stated that their family member had a weight problem and they wanted them to lose weight for health reasons. The survey showed that the relative thought their family member was safe from harm. The registered manager had taken action and the person had been referred to a dietician. However, the advice provided by the dietician had not been followed.

The home had an easy to read complaints procedure. The home had not received any complaints from people or their relatives. One relative told us that they did not have confidence in raising concerns or complaints with registered manager or the provider and that they would complain to the local authority if they needed to. This meant that the provider's complaints policy may not be effective because people and their relatives may not have the confidence to use it.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 22 December 2014 we identified breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff reported that the providers were not supportive. There was no evidence of quality audits in the home. We asked the provider to take action to make improvements. The provider sent us an action plan but did not provide timescales by which the regulations would be met.

At this inspection we found that some improvements had been made. Files were kept securely and were not left unattended when not in use. Records in staff supervision files showed that all staff had a meeting with a member of the management team in January 2015 to address issues of confidentiality found at the last inspection.

People were unable to verbally tell us about their experiences. We observed that the team leader and the registered manager spent time in the home and knew people well.

We received mixed views from relatives we spoke with. Seven relatives told us there was always someone senior that they could speak with. They said that the management team was available in the office. Three relatives told us they didn't think the service was well led. One relative told us that "The fundamental problem is the leadership is poor". However, one relative said, "They [the home] seem to be organised".

Records relating to people's care had not been completed effectively which meant that key information about events and incidents had not been recorded. There were gaps in one person's food diary which meant that there was not a complete record of the meals the person had eaten. We viewed records of meetings between the registered manager and one of the directors. The meeting notes contained discriminatory comments.

At our last inspection we found that the provider had not assessed the quality of the service and therefore failed to identify where improvements could be made and act on these. During this inspection, we found that this had not improved; there had not been any provider audits which had taken place. The only audits that had been carried out were infection control audits. We spoke with one of the directors who told us that they left the auditing of the service to the registered manager. Therefore, the provider was not aware of the quality concerns within the service and had not identified the issues that we found during the inspection. The registered manager told us that they had little support from the provider and did not receive formal supervision. There was a lack of leadership in the home.

A body map which had been completed following an incident on the 22 February 2015 showed that the person had scratches on their back as a result of the incident. However, the body map had not recorded that these injuries were as a result of physical abuse. A note written on the body map suggested that the injuries were caused by self-harm. The note said, 'Assessed possible self harming scratches or (other person) His self?' The daily records for the person who had received scratches did not evidence that there had been an incident and that they had suffered injuries.

This failure to assess, monitor and improve the quality of the service and maintain accurate, complete records was a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff shared that the vision of the service was to support people to live life to the fullest. Another staff member didn't know what the vision and aims of the service were, they told us they "Haven't seen the providers for a long time". People had not been supported to live life to the fullest, as there was limited opportunity. Some people were restricted from accessing the community and relatives were not always able to visit.

The registered manager worked in isolation from other social care professionals. We received mixed feedback from professionals; some told us that they had provided advice and guidance to the home which had not been followed. One local authority care manager told us "I have been in the position a few times where reviews have been cancelled at the last minute because something has come up only to be challenged by the family at a later date for me cancelling the review. I have had a parent who did not attend a review and when telephoned she had not been made aware". We received similar feedback from another local authority care manager. However, a nurse assessor told us, "A very well led service, with extremely knowledgeable and experienced management in place". Working in isolation meant that staff did not have appropriate guidance and support to enable them to provide care for people.

Inadequate

Is the service well-led?

This failure to work with other professionals was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The provider and registered manager had not notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations and incidents of abuse.

This failure to notify CQC was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Staff told us they felt free to raise any concerns and make suggestions at any time to the registered manager and knew they would be listened to. However, staff had contacted the Care Quality Commission (CQC) before we inspected with information of concern because they felt they had not been listened to. We followed this up during the inspection and shared it with the safeguarding authority. During the inspection staff told us that they were aware of the home's whistleblowing policy and that they could contact other organisations such as the Care Quality Commission (CQC) and the local authority if they needed to blow the whistle about concerns.

Staff told us that communication was good. One staff member told us "We have very good communication between the day and night staff". Another member of staff said that they had made a suggestion which had been listened to, this resulted in a person getting a new bed. Another member of staff said that "Staff were happy to share opinions and how to improve it [the service]".

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive appropriate care to meet their needs, which reflected their preferences. The provider had not worked in partnership with relevant competent health care professionals and had not involved relevant persons.** **Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c) (f)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect. People were not supported to have autonomy, independence and involvement with their community and with the relatives.** **Regulation 10 (1) (2) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People's consent and capacity had not been assessed in accordance with the Mental Capacity Act 2005.** **Regulation 11 (1) (2) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

	Risks to people's health and safety had not been appropriately assessed and managed. Food had not been stored effectively to mitigate the risks of cross contamination. Medicines had not been appropriately managed. Regulation 12 (1) (2) (a) (b) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Systems and process were not effective to appropriately report and investigate abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People did not always receive appropriate nutrition to meet their assessed needs. Regulation 14 (1) (2) (a) (i) (b) (4) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People were not protected from harm because equipment had not been properly maintained. Regulation 15 (1) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider had not maintained accurate, complete and contemporaneous records. The provider had failed to assess, monitor and improve the quality of the service

Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received appropriate training in order to meet the needs of people they provided care and support to. Regulation 18 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not notified CQC of events and incidents without delay. Regulation 18 (1) (4B) (a) (b) (c) (d) (5) (a) (e) (f)