Hilton Rose Retirement Home Ltd

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Inspection report

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Date of inspection visit: 2, 3 and 4 June 2015
Date of publication: 21/08/2015

Ratings

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

Overall summary

This inspection took place on 2, 3 and 4 June 2015 and was unannounced. At our last inspection in August 2014 we found the provider was not compliant with the requirements of the law with regards to safeguarding people from abuse, management of medicines, assessing and monitoring the quality of service provision and records. The provider had submitted an action plan regarding the actions they would take to improve. We saw that some areas had improved, for example, there were now risk assessments present for the kitchen. Insufficient improvements had been made overall and some areas had not be adequately addressed.

Hilton Rose Retirement Home is a residential home that provides accommodation for up to 25 older people who require personal care. At the time of our inspection 25 people were living at the home. The majority of people currently living at the service have dementia. There is

Summary of findings

currently a registered manager in place. 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.

During our inspection, we found that people's medicine was not always received as directed by their doctor. We found errors with the administration and recording of medicines and we observed unsafe practices when staff were giving people their medicine.

People were not always receiving appropriate support due to insufficient staffing levels at certain points during the day. We observed people waiting for support and sometimes attempting to complete tasks independently that they required support with due to the lack of available staff.

People were not protected from abuse due to unsafe recruitment practices. We saw the absence of background checks such as DBS certificates and references.

We found inadequate risk management within the service. This included call bells that allow for people to call for support being out of people's reach, inadequate risk assessments and people being supported to move in a way that could cause an injury.

Staff could explain what abuse was which showed they could recognise signs of potential harm. Staff could describe how they would report abuse and told us that they would be happy to whistle blow if they were required to.

We found issues with hygiene within the home during our inspection. These issues included a smell of urine in certain areas, unclean communal areas and poor hygiene practices of some people living at the home following visits to the toilet with insufficient support.

We found that people's capacity had not been assessed in line with the required legislation and people were not consenting to the support they received. We saw that where people's liberty was being restricted in order to protect their safety and well-being, appropriate applications had been submitted to the local authority in most cases.

We saw that people were not always supported to effectively maintain their health. People had regular access to the GP, optician and chiropodist although most people within the service had not seen a dentist for several years. We did not see evidence that people with diabetes had seen a chiropodist recently. We found examples where instructions from external healthcare professionals had not been identified and implemented.

We saw that staff were given opportunities to complete further qualifications such as a diploma in health and social care or in dementia. We also saw that training had not always been completed in the areas that staff were working. Staff told us that they felt supported in their role and had regular one to one meetings with their manager.

People told us that they enjoyed the food they ate and adaptations had been made to meals for special dietary requirements such as diabetes.

We saw people's privacy and dignity being compromised during our visit. In particular with people visiting the toilet with doors open and being left with aprons on and food down them for a lengthy period of time.

We saw that there were dementia friendly aids present within the service such as handrails and adaptive toilet seats to assist people with their independence. However, certain things were observed that would disorientate someone with dementia, such as clocks showing the incorrect time.

People were not actively involved in making decisions about their care and the development of their care plan. We observed staff involved in positive, caring interactions with people. We also saw situations where staff made decisions without consulting people, for example changing TV channels in communal areas.

We saw that the care people received and their care plans were not always updated in line with their changing needs. Staff told us that they felt care plans were up to date which demonstrated that staff may not always be aware of people's current needs. People were not encouraged to pursue a range of leisure opportunities.

Feedback surveys were completed to obtain people's views on the service. Staff told us that they always obtain feedback from people when they support them, either verbally or by monitoring their reactions and enjoyment.

Summary of findings

We found that there were insufficient audits and quality assurance processes in place. We saw that audits that were in place didn't always identify issues and concerns.

Staff felt that the management team were approachable and they were happy with the level of involvement both they and the people living at the service received.

We found areas in which the provider was not meeting the requirements of the law. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'inadequate'. This means that is 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.
- Provide a clear timeframe within which the providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measure will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People did not always receive their medicines safely or as prescribed.

People were not always receiving appropriate levels of support due to insufficient staffing levels and we found that staff had not always had appropriate recruitment checks completed.

People were not always protected from harm due to inadequate risk management and hygiene practices.

Inadequate

Is the service effective?
The service was not always effective.

People were not always supported to effectively maintain their health.

People's capacity had not been assessed in line with legislation and therefore their consent to care and support given was not always obtained.

People enjoyed the food and drink they were given.

Requires improvement

Is the service caring?
The service was not always caring.

We saw people's privacy and dignity being compromised during our visit and people weren't always supported to be as independent as they could be.

People were not always involved in decisions around planning their care or day to day events within the service.

People were supported to maintain relationships with their relatives and friends.

Requires improvement

Is the service responsive?
The service was not always response.

People's individual needs were not addressed in their plans of care and updates to people's plans were not made in line with any changes.

People were not encouraged to access a range of leisure opportunities. People were not supported to be independent due them not being able to access appropriate aids such as hearing aids and glasses.

Requires improvement

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

People were not supported by a service that was managed by a robust leadership and quality assurance framework. Audits were not always in place and those completed did not identify issues or concerns.

Effective systems were not in place to identify and record people's changing needs and to communicate these needs to the staff teams.

People were aware of who the managers were and we were told that staff felt they were approachable.

Hilton Rose Retirement Home Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 2 June, 3 June and 4 June 2015 and was unannounced. The inspection team included two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification is information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with eight people who lived at Hilton Rose Residential Home. Some people who lived at the service had dementia and some were therefore unable to share their experiences. 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 spoke with nine members of staff, four visiting professionals and seven visiting relatives and friends. We reviewed ten records relating to medicines, four people's care and records relating to the management of the service. We also carried out observations across the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in August 2014 we found that there were issues with the management of medicines, management of risk and investigating and reporting safeguarding concerns. The provider sent us an action plan outlining how they would make improvements. Despite an action plan being in place, we found evidence of continued poor practice in how people's medication was being managed safely.

People's medical conditions were not always being treated appropriately by the use of their medicines. We found some of the medicines administration records were not able to show that people were getting their medicines at the frequency that their doctor had prescribed them. We found that one person had not received two doses of their blood thinning medicine over a four day period. We also found that one person had not received the correct dose of their two inhalers. The first inhaler was prescribed at two doses to be inhaled twice a day and we found that this person had not received 41 doses out of the 108 doses that had been confirmed on the administration record. The second inhaler was prescribed as one dose to be inhaled daily and we found that this person had not received 5 doses out of the 25 doses that had been confirmed on the administration record. The provider was unable to provide an explanation as to why certain medicines had not been administered.

One person was identified by the provider as needing to have their medicines administered by disguising them in food or drink. The provider did not have all of the necessary safeguards in place to ensure that these medicines were administered safely. We were particularly concerned that the staff were crushing modified release tablets when it clearly stated on the dispensing labels "Swallow this medicine whole. Do not crush or chew". Where people were having medicinal skin patches applied to their bodies, we found the provider was not making any record of where the patches were being applied. One person was not receiving these patches at the frequency prescribed for them and the provider was not able to offer an explanation as to why. The provider therefore was not able to demonstrate that these patches were being applied safely or that the person was receiving adequate pain relief.

We observed the practice of administering medicines and saw that a medicine was dropped on the floor with the staff member continuing to give the medicine to the person. We observed two members of staff conducting the administration process. One member of staff prepared the medicines and the second took them to people and administered them. This practice leads to administration errors and staff involved were unable to explain how errors we found had arisen.

We observed the refrigerator temperature records and found that the monitoring was not ensuring that medicines were being stored correctly so they would be effective. We found that the maximum and minimum temperatures of the refrigerator were not being monitored on a daily basis.

We observed one person asking for cream during the inspection and being told that the provider had run out. We saw this person's anxiety around the missing medicine increase during our inspection. We saw records written by a visiting nurse confirming they were unable to apply another person's cream due to it having run out.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always kept safe from harm or their needs met and managed safely due to insufficient numbers of staff available to provide support. One person told us "The trouble is there is not enough staff for them to take proper care of me." A visitor told us "My relative has good and poor carers but at times there are not enough of them on duty, they are rushing around so my relative has to wait until someone comes to help."

We observed two people calling for help from their bedrooms and inspectors had to intervene to locate staff to assist them. We saw one person with mobility issues walking unaided across a lounge area without support. An inspector intervened to ensure they were safe until a staff member was available to support. We observed someone trying to get outside through a curtain and window and we called a member of staff again to support. Another example arose when a resident had sat themselves in front of some open patio doors in the lounge area which were in use. There were no staff present in the lounge to move the person to a safer area and people did try to enter while this person was in front of the doors. At the same time, someone was left sitting with a split drink and their cup lying on its side and another person was walking unaided across the lounge struggling to put a cup onto a table.

Inadequate

Is the service safe?

A member of staff told us that they needed one additional person in the afternoon. We discussed this with the registered manager and she confirmed that this had been considered and she would review staff levels and the deployment of staff. The registered manager confirmed that there were no formal systems in place for identifying the number of staff required to effectively meet people's needs.

This is breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by the provider from potential abuse. Staff were not always sufficiently vetted for the roles they were working in to ensure their suitability to support the people living at Hilton Rose. One person was working in the home without any ID or background checks having been completed and without evidence that they were qualified to complete the role they were carrying out. Another person had insufficient ID and background checks completed, including not having a valid DBS and references being obtained after their first day of employment. A DBS from a previous organisation had been used but had not been verified through the DBS's Update Service as being current. The registered manager was not fully aware of the requirements of the Update Service. DBS checks were not updated in line with industry best practice or when staff moved into a new role.

We found that evidence was not available to demonstrate that staff were suitable to work in the positions they were employed in and gaps in their employment history weren't identified and investigated. There were no risk assessments in place where staff had commenced work with insufficient checks completed. The registered manager confirmed that the discrepancies had not been identified prior to our inspection.

This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate risk management by the provider and registered manager meant people were not protected from potential harm. We found call bells that enabled people to alert staff they needed support were sometimes inaccessible or out of reach. We found one call bell cable and button on the floor behind the wheel of someone's bed. This person was currently being cared for in bed, they were not able to mobilise independently and they could not call for help if needed. We found another call bell behind a chair in a lounge area. We discussed this with the registered manager and were advised that they relied on people being able to get up and move to this bell or for another person living a the service to call for help. On the second day of our inspection longer call extension cables had been fitted to some bells and the registered manager advised that she had arranged for more accessible call bells to be fitted in the lounge areas.

We observed one person in the lounge without their glasses and hearing aid. Their risk assessment told us that they should have these items available at all times in order to keep them safe. We were told that the person's glasses were in their bedroom and their hearing aid had broken several weeks previously. A replacement hearing aid had not yet been sourced. This person's risk assessment also stated that they should be transferred at all times with a hoist. The registered manager told us that this risk assessment wasn't accurate as the person could mobilise independently. We later saw staff supporting this person to move from a chair to a wheelchair in a way that could cause risk of injury to the person. We saw other people being supported in wheelchairs inappropriately, without foot support, in a way that could also cause injury to those people. The registered manager confirmed that foot support should be used on wheelchairs although the manager and staff were unable to confirm why it wasn't always being used during our inspection.

One person was being cared for in bed and staff were unable to describe to us why this was. We saw this person had bruising to their arms and staff gave different reasons for these bruises. For example, some staff said that the person rubbed their arms and others told us the person had injured themselves on their bed sides. There was no assessment of risk to this person from having the bed sides in place. We saw that a community nurse had recommended this person have a high fibre diet. This was recorded in the nurse's care record that was kept at the service yet staff and managers had not identified this need. Risk assessments had not been updated since this person was able to walk independently and staff were not managing the risks to the person's health effectively. We saw another example of a person whose weight had dropped 8.5kg in a two month period. Staff were unable to tell us about any changes in the management of the care for this person following the drop in weight and some staff were unaware that the weight loss had arisen. We saw that the person's weight was being recorded more frequently

Inadequate

Is the service safe?

but an effective plan to manage the risks for this person had not been developed or communicated to staff. The registered manager advised that they would develop a more effective system for ensuring staff are aware of people's needs.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

Staff could describe what abuse was and how they would report any concerns if they witnessed abuse. They understood that there was a wide range of ways someone could potentially experience abuse and made comments including "doing anything that would harm them" and "It's not just physical and sexual. It's also not giving people choices." Most relatives told us that they felt people were safe at the service. One person living at the service told us "I feel safe sometimes but not other times". Another told us "It's lovely here, I have no problems with anyone. I feel safe and well cared for by the carers who look after me very well."

We found there was a strong smell of urine in the corridor at the front of the home and also in the lounge area at certain points during the day. The registered manager was unaware of the scent however one member of staff told us that the provider had spent time working to remove the smell and had tried various things including urine treatments. We highlighted the scent in the lounge to the registered manager during our inspection and they confirmed that they could also smell urine. We found that the communal areas were often left unclean with food on carpets several hours after meals were served. We confirmed that the current cleaning schedule meant these areas were only cleaned by night staff. After raising this with the registered manager, we saw on the second day of our inspection that domestic staff were vacuuming lounge areas after meal times.

Requires improvement

Is the service effective?

Our findings

At our last inspection in August 2014 we found that there were issues with the completion of assessments of people's capacity to make decisions or provide consent and also with the submission of applications to the local authority where a person's liberty had been restricted in order to protect their safety or well being. The provider submitted an action plan telling us how they were going to make the improvements. However at this inspection we identified more evidence that the improvements had not been fully implemented and maintained.

People were not always enabled to make decisions and consent to the care they received. We were told by some people and their relatives that they had not been involved in a discussion around their support needs. One person told us "no one has talked to me about what I need or what care needs I have", "I have no information or told what's happening". Another person told us "I don't know anything about a care plan or if it's written down anywhere. I can't even remember anyone talking to me about what I need." One visitor said "Nobody has ever talked about what care my relatives needs. I have no information or resident information pack either. We know nothing that's going on."

We were told by the deputy manager that 90% of the residents had dementia and therefore had limited capacity with regards to making decisions and consenting to their care. Where people did not have the capacity to consent, their capacity had not been assessed in line with current guidelines and legislation. There was no evidence that decisions were being made in people's 'best interests' and in consultation with other people including professionals and representatives. People were assessed as either having capacity or not and fluctuations in their capacity or the types of decision someone could make were not considered. The deputy manager acknowledged that the capacity assessments completed didn't meet people's needs as they were too generic and advised us that she was in the process of revising these assessments.

Staff that we spoke with weren't always able to explain the principles of current legislation surrounding capacity and people's consent. Information provided by the registered manager showed that training had not been completed around this legislation or the practical application of the law. We observed one member of staff wipe a person's face and hands without gaining consent which resulted in the person becoming distressed and shouting out. We identified that medicines were given in some instances without consent and without one person's knowledge. The correct procedures had not been followed in line with current guidance and legislation.

This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activity) 2014

Staff could describe how they would gain consent from people when supporting them. We were told "If they really don't want it we won't force them" and staff described how they would offer alternatives such as having a wash if someone didn't want a shower. We saw some examples of staff gaining consent before they supported people and we also saw examples of when they did not.

Where people's liberty was being restricted in order to protect their safety and well being, we were advised by the manager that the relevant applications required by law had been submitted to the local authority. We confirmed with the local authority that they had received 13 applications from the provider. There were two applications that the manager had advised were submitted that the local authority confirmed had not been received.

People were not always supported to effectively maintain their health. We observed two people with poor dental hygiene and found no evidence of recent dental visits in their care records. We asked the registered manager to provide of list of people's last dental appointments and found that these people hadn't seen a dentist since 2011 and 2013. We found that only one person had seen a dentist in 2014 and none had seen a dentist in 2015. The registered manager confirmed that they had been unable to source a current dentist that was able to visit the service and alternative arrangements had not made.

We found that most people had regular access to a chiropodist however, information provided by the registered manager following our inspection showed that three diabetic residents had no date recorded for their last chiropody appointment. Regular foot care is particularly important for people with diabetes as their condition can cause a reduction in the blood supply and feeling in the feet and can lead to more complex health concerns.

We found two examples of instructions provided to care staff by community nurses that had not been carried out. We saw that nurses had recommended a high fibre diet for one person and this had not been implemented. We saw

Is the service effective?

another example of a nurse recommending the use of a specific tool when monitoring blood glucose in people with diabetes. The registered manager had not identified this recommendation and blood glucose levels were only monitored after a verbal instruction from another nurse. The registered manager confirmed that they were reliant on verbal instructions and that nurse records were not checked for any changes in peoples requirements. During our inspection the registered manager spoke to nurses and requested that specific instructions are logged in the service's daily records in addition to the nurse file.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had regular access to a GP and optician. Staff told us that the optician was trained in dementia and therefore was particularly effective when working with people at the service.

We found that people had been given the opportunity to complete further qualifications. We saw some staff either had completed or were in the process of completing vocational qualifications in Health and Social Care and some were completing a qualification in dementia. Staff had regular one to one meetings and most told us that they felt supported in their roles. Staff told us that they had an induction on joining which involved shadowing more experienced care workers. Care staff told us that during their induction "[Staff] were brilliant" and "When I first started [person's name] and [person's name] went round with me to make sure that I was comfortable."

People told us that they enjoyed the food they ate. One person said "The food's very nice and we have choice at each meal time." Another person said "They sometimes cook me some Caribbean food, I do like that". The staff we spoke to were aware of the people with diabetes living at the service and people told us about one person not being able to eat pork due to their religious beliefs.

We observed some people were supported to eat with the use of specific aids, assisting them to be more independent. We saw some people served light coloured food on white plates, which can be challenging for people with dementia or visual impairments. In addition we saw people at tea time struggling to balance and keep food on their plate as they had been served sandwiches on their laps using small plates. We saw alternatives being offered for those with dietary needs, for example reduced sugar squash although this was not consistently done. For example, we saw two diabetic residents offered normal biscuits when the diabetic versions had run out. We found that breakfasts were served flexibly to meet people's preferences around the time they got up. People were given regular drinks and snacks throughout the day. We were told by the cook that menu's were planned by the registered manager, the deputy and the cook a week in advance and people were given two meal options at lunch and for their evening meal. We saw minutes from a residents' meeting where people had requested specific food items and it was minuted that these requests were actioned.

People were not always offered support to eat their meals when needed. We observed an example of 11 people in one lounge area eating a meal with no staff members present. One person was seen sitting with their breakfast in front of them and food down their front with no assistance given by staff.

Requires improvement

Is the service caring?

Our findings

We found that people were not supported to protect their privacy and dignity and saw examples of how these were compromised. For example, we observed three people using toilets with the doors open. Whilst one toilet was in use we saw another person walking in on them because the level of support they required had not been correctly assessed and they had not shut and locked the door behind them. One member of staff told us "we do have residents who sit on the toilet with doors open". They told us that they would shut doors when they saw them open but there were no steps taken to prevent this from happening. One person was seen using a toilet with another person's faeces on the toilet seat. We had a discussion with the registered manager about these issues and were told that some people were assessed as being able to go to the toilet independently and they were unable to prevent other people from "wandering off". The manager later advised that they would look to install soft close hinges to ensure that doors would close behind people.

We observed staff discussing people and their needs inappropriately in communal areas. For example we heard peoples' needs such as diabetes discussed openly, we heard staff laughing about one resident who had misunderstood the use of an aid to support their hearing and we heard staff discussing one residents daytime sleeping preferences. We observed people sitting in lounge areas with protective aprons on that were covered in food following mealtimes. We saw that people were left with these aprons on for significant periods of time. One person was seen sitting with an apron on for over one hour and another was seen having their breakfast apron taken off as a mid morning snack was being served. We discussed this with the registered manager who was not able to provide an explanation as to why this happened.

We observed people with stained clothing, food on their clothes and we saw one person with food debris around their mouth. We saw one person sitting with their skirt dipped in a cup of tea, staff removed the skirt but left them sitting in wet clothing. We observed another person sitting in their room with a wet patch on their trousers. One relative told us that they had often seen their relative wearing other people's clothes.

People weren't always supported to be independent. We saw one person was not wearing their hearing aid as it had been lost during a recent hospital visit and a replacement had not yet been sourced. This person was not able to communicate effectively without this aid and we observed their visitors highlighted how distressed they were becoming without it. As a result of this intervention the deputy manager arranged a visit to a drop in clinic to obtain a replacement the following day.

People were supported by staff who were caring although interactions were not always observed to be warm and supportive. One example was seen of a staff member supporting a resident who had lost a personal item, the interaction was unsupportive with the staff member was heard saying "look in your drawer". We described to the manager that some of the interactions we observed were uncomfortable and staff didn't have regular warm, caring conversations with people during our inspection.

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not actively involved in making decisions about their care. Some people told us that they weren't consulted about their care needs. People's capacity wasn't effectively assessed and recorded and therefore their contribution to their plan of care and the involvement of other representatives was not completed in line with current legislation and guidance. We saw several examples of people not being consulted by staff about their environment. We observed three examples of staff changing channels on the TV or putting music on without consulting people who lived at the service who were in the room. We saw drinks being given to people without them being given a choice of what sort of drink they would like.

We found examples of people's independence being promoted. We saw that a brightly coloured toilet seat and wall rails had been fitted which is supportive to people who have dementia or are visually impaired. Each bedroom had clear signs with pictures to help people identify their room. We were told by one person "When they shower me I do most of the things myself as I'm more than capable. Staff sit me on a chair in the shower room and they make sure that I'm okay".

One person at the service told us "staff look after me very well and they are kind to me. They know what I want and need". A visitor said "each time I come to see my friend, the staff are always polite and caring." A visiting professional told us "I've always been happy with the care I've seen".

Requires improvement

Is the service caring?

Staff were able to describe how they make people feel valued and cared for. One staff member said "[person's name] doesn't come out of her room and thinks it's her bungalow. If you go down and have a cup of tea with her she thinks you've visited her in her home."

Requires improvement

Is the service responsive?

Our findings

People's care needs were not always being met and plans of care did not reflect current needs. The staff we spoke to were also not always able to advise us of people's current needs. One care plan did not reflect the change in a person's needs following a recent hospital admission and discharge. The staff that we spoke to were unable to explain to us this person's up to date condition and needs which meant we were unable to obtain evidence that the person's care needs were being met.

People's preferences were not always reflected in the care they received. People weren't supported to follow personal interests or encouraged to take part in regular leisure opportunities. One visitor described their relative as a 'TV addict' and then went onto say how much pleasure they would get from having a TV in their room if they could bring one for their use. We spoke to the registered manager about this individual and they told us that a visiting professional had also raised this earlier in the day. The registered manager said that if someone had told them then they would have arranged this although the information had not been proactively sought. We also found that someone was unable to look at photographs that were important for reminiscence due to their glasses having gone missing. When we discussed this with the registered manager, we were told that they were unaware of the missing glasses.

Relatives and staff told us that they enjoyed a recent event to mark the 25 year anniversary of the service. We saw that a volunteer activities coordinator was present during our inspection completing armchair exercises with people. One resident told us "there isn't much to do here, we have the odd games and bingo sometimes". A relative said it would be beneficial if there was more for people to do, this even being a walk to the local park across the road. A visiting professional also told us that they would question if there are enough activities and stimulation for people. We saw two clocks in communal areas and one clock in someone's bedroom showing the incorrect time. This can be very disorientating for people with dementia and was not supportive in meeting their needs.

People told us that they would raise any concerns or complaints with the staff and managers at the service. One resident said "If I was upset about anything I would talk to the carers." The registered manager advised that they were unaware of two issues that relatives had told us had been raised with managers. We saw that a complaints folder was present with a summary of the nature of complaints received but we saw no evidence of any investigations that had taken place. A complaint was raised with the registered manager by a relative on day one of our inspection. This had not been logged during our visit.

We were advised that complaints would be escalated to the registered manager or deputy manager to deal with. The minutes from a management meeting held 1 June 2015 confirmed an action point that it had been previously noted that not all significant customer issues were being recorded / captured in the complaints system and managers were to remind all of the importance of this. However staff we spoke to were unsure of the processes for recording complaints. The complaints policy states that an annual report will be prepared each year summarising the complaints received, the nature of these and improvements that will be made. It was confirmed that this had not yet been done.

We saw evidence of feedback surveys that had been completed recently and a summary of the responses had been collated. The registered manager advised that surveys had been modified to ensure more information is captured about the quality of care provided. Staff told us that they regularly receive verbal feedback from people living at the service. They told us that they monitor peoples' reactions and enjoyment where people are unable to give verbal feedback although this isn't formally recorded and analysed. One member of staff told us "when I come on shift I'll always ask people how they are and if they're ok. If I feel like [one of the people living here] aren't acting themselves I'd query this."

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2014 we found that there were issues with audits being completed for health and safety, medicines, accidents and incidents. The provider sent us an action plan outlining how they would make improvements. At this inspection we continue to have concerns about the governance arrangements in place which ensured people received safe, effective and compassionate care.

People had been put at risk due to audits that were in place being ineffective. The medicines audits had failed to identify errors such as missed medicines, people running out of medicines and inaccurate record keeping. The deputy manager acknowledged that the audits had failed to identify the errors that we had found. We were told that the provider was regularly carrying out assessments on their staff to ensure they were competent to administer medicines safely, however the results of these observations were not being recorded so the provider was not able to evidence that staff were competent.

The provider was unable to evidence that a sufficient quality assurance system was in place to identify areas for improvement and to manage risks. There were no audits completed or system in place for identifying and managing trends arising from complaints, accidents, incidents or other concerns such as body charts which are used for mapping damage to peoples skin. There was no audit of staff files which had resulted in errors remaining within peoples recruitment records and some records relating to one staff members one to one meetings had gone missing.

The registered manager had no system in place for monitoring the personal possessions of people leaving and re-entering the service due to events such as hospital admissions. This had resulted in the loss of one person's hearing aid during a recent hospital stay. We discussed this with the registered manager who had previously considered this to be the responsibility of the hospital. We were told that the registered manager would develop systems to manage this moving forwards.

We saw that the provider had not reviewed and updated the care that people received as a result of their changing needs identified as a result of any involvement by external healthcare professsionals. There were no systems in place for the manager and care workers to identify these needs unless the external professional provided verbal feedback at the end of their visit to the registered manager or the deputy manager. We also found that systems were not in place to ensure that staff were made aware of essential changes in people's needs.

We saw that other records in relation to the management of the service weren't always up to date. We saw a record of electrical testing having been completed in May 2015, however no certificate was present. The registered manager confirmed that this was because the electrical testing did not go ahead and they were due to visit on the following day.

We saw evidence of minutes from management meetings that were taking place on a monthly basis. The most recent minutes show that while the management team are discussing quality and systems, they have not identified the issues that our inspection team have found.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) 2014.

We discussed these concerns with the registered manager who acknowledged that there was a need to implement a full quality assurance system. The registered manager told us that they would review the roles and responsibilities within the management team immediately and would take action to strengthen the current management structure.

The provider is required by law to submit notifications to CQC of significant events. We saw copies of eight notifications that the registered manager told us had been sent, including two fractures, which have not been received by CQC. The registered manager has been unable to provide us with any evidence that these were sent. We have received three further, more recent, notifications that were shown to us by the provider.

The provider had not developed a team structure where it was clear to staff what the responsibilities of each job role were. We asked one person to explain the difference between team leaders and senior care staff and they were unable to do so. We asked another person whether they would record complaints or if this was the responsibility of management and they were unsure. One member of staff told us that they felt they were unable to raise issues with managers as their concerns wouldn't be confidential. Another member of staff told us that they felt it would help if staff were given an opportunity to talk about issues openly at monthly team meetings.

Inadequate

Is the service well-led?

Most staff told us that they felt motivated and were happy with the managers. We were told “we can put our views across and have our input” and “[Name] is a good manager, [they’re] good with staff, [they] talk to us and not down to us.” Another person told us “We all feel included and the residents. I like coming to work.” Relatives also fed back that the management was approachable although we were made aware of issues that relatives said had been raised although these hadn’t been followed up. The registered manager told us that they were unaware of these specific issues.

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 10 HSCA (RA) Regulations 2014 Dignity and respect People's privacy and dignity was not always respected and protected.

The enforcement action we took:
We are considering the action we will take in response to this breach of the regulations and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's consent to their care and support was not always sought in line with current legislation and guidelines.

The enforcement action we took:
We are considering the action we will take in response to this breach of the regulations and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People did not always receive their medicines safely and as prescribed. People were not protected from harm due to inadequate risk management and a failure to ensure that staff were fully aware of people's care needs.

The enforcement action we took:
We are considering the action we will take in response to this breach of the regulations and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider had failed to ensure that an effective quality assurance system was in place to identify risks and errors and to drive improvement.

The enforcement action we took:
We are considering the action we will take in response to this breach of the regulations and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of qualified and suitably skilled staff were not always available to support people.

The enforcement action we took:
We are considering the action we will take in response to this breach of the regulations and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had failed to ensure that people were protected by safe recruitment practices.

The enforcement action we took:
We are considering the action we will take in response to this breach of the regulations and will report on this when the action is complete.