The Alder Health Care Group Limited

Radcliffe Gardens Nursing Home

Inspection report

11 Radcliffe Gardens
Pudsey
West Yorkshire
LS28 8BG

Tel: 01132564484

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05 June 2018
08 June 2018
20 June 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5, 8 and 20 June 2018 and was unannounced. This was the first inspection we have carried out at this location since a change to their registration in February 2018.

Radcliffe Gardens Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Radcliffe Gardens Nursing Home is registered to provide accommodation for up to 20 people who require nursing or personal care. The home is located in a quiet area of Pudsey and close to local amenities, shops and churches. The home is on two levels with lift access and has a garden area and car parking to the front of the building. At the time of this inspection, 17 people were using the service and all were receiving nursing care.

There was no registered manager in post. 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.

We identified a number of concerns relating to fire safety. This included the service not having an up to date fire safety risk assessment in place, a number of 'immediate' actions on the previous risk assessment from June 2014 which had not been addressed and insufficient staffing levels at night. This put people at risk of harm. Following our inspection, we contacted the fire service and they visited the service and issued an enforcement notice.

An electrical test dated October 2012, which, in line with best practice guidance required a retest in October 2017, had not been completed at the time of our visit. The provider told us they had arranged a retest and would send us the certificate. We have not received this.

Medicines were not managed safely. Care staff had not completed training they required to assist nurses when they administered controlled drugs. Guidance for staff to follow when administering 'as required' medicines was not available. This meant people were at risk of not receiving their medicines when they needed them.

The provider did not consider people's needs when they arranged staffing levels at the service. Staff and people we spoke with said staffing levels were not sufficient to meet people's needs. Most people using the service required the assistance of two staff to have their care needs met. Current staffing levels compromised people's safety and meant they had to wait and were limited as to when they could have a bath or a shower. Staffing shortages often meant that the activities staff were included in the numbers and therefore, were not available to facilitate planned activities.

Quality assurance systems were in place and internal audits had been completed, however these were not robust enough to identify any areas of concern we identified during our inspection.

The provider did not have a policy in place regarding the Accessible Information Standard. We have made a recommendation about this.

The provider did not ensure information about how to access advocacy services was available for people. We have made a recommendation about this.

There was a large communal lounge where most people spent their time. We saw no other space dedicated as a quiet area for people to sit or to see their relatives and friends.

Staff told us they received regular supervision and annual appraisals.

Recruitment practices were safe and thorough. Staff demonstrated a good understanding of how to protect vulnerable adults. They told us they had attended safeguarding training. Policies and procedures were in place to make sure any unsafe practice was identified and people using the service were protected. People told us they felt safe and knew how to report concerns about their safety if they had any.

Systems were in place to ensure accidents and incidents were dealt with appropriately and monitored by the service.

During our visit we observed staff were attentive to people, we saw them speaking in a warm and respectful manner to people. Staff demonstrated that they knew people's individual characters, likes and dislikes. People were treated with dignity and respect by the staff supporting them and our observations were that people's independence was promoted at every opportunity

People's nutritional needs were met and they had access to a range of health care professionals to maintain their health and well-being. Care plans were person centred and individually tailored to meet people's needs. Care delivered on a practical level was also person-centred. We looked in people's bedrooms and found people had personalised their rooms with ornaments and photographs.

Staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The service worked in partnership with other health and social care organisations to achieve better outcomes for people.

There were systems in place to ensure complaints and concerns were fully investigated. People who used the service and their relatives were aware of how to report concerns.

In the absence of a registered manager the deputy manager was aware of the requirement to notify CQC of specific incidents and displaying the current CQC rating.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant

improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

There were a number of issues relating to fire safety which had not been identified or addressed by the registered provider.

Staffing levels were not sufficient at all times which meant people's needs could not always be met and their safety compromised.

Arrangements were not in place to ensure the safe management of medicines. Care staff had not received training to assist nursing staff when they administered controlled drugs.

Is the service effective?

Requires Improvement

The service was not effective.

Systems were not in place to ensure staff competency was checked following the completion of training.

Dates for refresher training were not booked.

People's mental capacity had been assessed and the provider had made appropriate Deprivation of Liberty Safeguards applications to the Local Authority.

People had access to healthcare professionals when required.

People's nutrition and hydration needs were met.

Is the service caring?

Requires Improvement

The service was not caring.

The concerns noted in relation to the provider meant we could not be confident of the caring nature of the provider.

People and their relatives told us staff were very caring and attentive.

Staff were caring, kind and compassionate in their interactions with people and relatives.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were not always able to take part in activities and follow their individual interests due to staffing shortages.

People's preferences were understood and they were involved in their assessments. They were not always involved in the development and review of their care plans.

People had opportunities for discussions about their wishes for end of life care.

There was a procedure in place for managing complaints.

People and relatives knew how to raise concerns or make a complaint.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post.

The inspection team identified multiple concerns which had not been identified by the provider.

The provider had systems in place to monitor the quality of the service however, these were not robust. People were put at risk because the provider had failed to take appropriate steps to ensure people's safety.

There was no clear management structure in place. Staff told us they did not feel valued by the provider and some staff had never met them.

Radcliffe Gardens Nursing Home

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5, 8 and 20 June 2018 and was unannounced.

The inspection was carried out by one adult social care inspector on 5 and 8 June 2018. On 20 June 2018 the inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events such as accidents or incidents, which the provider is required to send us by law. We did not ask the provider to complete a Provider Information Return prior to this inspection.

Prior to our inspection we received concerning information. The concerns were in relation to the provider and their lack of involvement with the service. We shared these concerns with the local authority, and other commissioners of the service. We have continued to share information with the local authority during this time, to ensure people using the service are safe.

We spoke with three people and two visiting relatives. We spoke with the registered provider, the deputy manager and other staff who included the administrator, nurses, care workers, activity staff, housekeeping staff and catering staff. We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the care records for two people and medication records for all people using the service. We examined how medicines were being managed by looking at storage, administration and records relating to this. We inspected the environment and equipment being used by people and staff. We also looked at four staff recruitment files, records of staff training and supervisions, records of complaints, accidents and incidents and other records used by the provider such as quality monitoring audits and reports. At the end of the inspection we gave feedback to the registered provider. We asked the provider to send us additional information following our inspection, however, we did not receive all that we had requested.

Inadequate

Is the service safe?

Our findings

Fire safety systems at the service were not safe and as a result, people were put at risk of significant harm. We reviewed the safety of the premises and identified a number of issues relating to fire safety which we reported to the provider immediately. A fire risk assessment of the service had not been carried out since June 2014. The purpose of having a fire risk assessment is to identify all fire hazards, to reduce the risk of those hazards causing harm and to decide what steps are required to be taken by the provider to ensure the safety of staff and people using the service. The fire risk assessment dated June 2014 showed 16 'immediate' actions which had not been addressed by the provider. For example, there were no evacuation aids for staff to use to assist people in the event of a fire. This meant people accommodated on the first floor of the service were at risk as staff may not be able to assist them to a point of safety without this equipment. The fire alarm system at the service did not show all areas of the premises. This meant staff may not be able to identify the location of a fire. Recommendations to update the system had not been addressed by the provider. The provider had also failed to ensure that staff had undertaken practical aspects of fire training to ensure they were skilled and competent to assist people safely.

Each person also had an 'evacuation risk assessment' which identified the level of support and number of staff they would need to assist them in the event of a fire. Fourteen out of the 17 people using the service required two staff to assist them in the event of an emergency. At night, between 7.30pm and 8am, there were only two staff on duty. This meant there were not enough staff on duty at night to assist people safely in the event of a fire.

Following our inspection, we reported our concerns to the West Yorkshire Fire Service. They visited the service on 14 June 2018 and issued an enforcement notice on the provider of the service. This stated that the provider is required to make fire safety improvements to the premises by 20 August 2018. Following the inspection, the provider worked with the fire service to ensure safe staffing levels were provided at night. The fire service have told us that they will revisit the service to ensure all other actions required to ensure people's safety have been taken.

The management of medicines was not safe and the provider did not follow their own medication management policy. The provider medication policy stated, 'A second, appropriately trained designated member of staff must witness the administration of controlled drugs'. We found care staff had not received appropriate training to ensure they were skilled and competent to assist nursing staff when they administered controlled drugs to people. Care staff also acted as a witness when the service received controlled drugs from the dispensing pharmacy. We saw care staff had regularly signed documentation relating to this. This meant the provider had failed to ensure people received their medicines as prescribed, from staff who had completed an appropriate level of training.

There were no instructions for staff on how or when to use 'as required' medicines. The provider's medication policy stated, 'When providing staff with information, the needs of the person must be identified e.g. if signs of pain are expressed in a non-verbal way.' 'Clear instruction must be obtained from the prescriber as to the indications for the medication and under what circumstances it may be administered. It

must be agreed between the individual and the care team as to how this medication will be requested and/or offered.' We reviewed people's medication administration records (MARs) and saw one person was prescribed a controlled drug for pain relief 'as required' up to four times daily. We saw there was no guidance for staff to show under what circumstances they should administer the medication in the form of a 'PRN protocol'. This meant people were at risk of not receiving their medicines when they needed them.

The information above is a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed records relating to the maintenance of the premises. A five-year electrical safety certificate dated October 2012 gave a date of October 2017 for a retest. This had not been done and meant we could not be assured of the electrical safety of the promises. During our inspection, the provider told us they had rebooked the test and would send the certificate to us. We did not receive this. Other certificates and reports were available to show maintenance and servicing of the premises and equipment used to support people had been completed.

Staffing levels were not sufficient to ensure people's safety or meet their needs. The provider did not use a dependency tool to calculate staffing levels. Rotas showed that regular staffing numbers for the service were four staff on duty during the day and two staff at night. Staffing rotas showed shortages in numbers to three staff on 12 shifts out of 28 shifts between 2 April 2018 to 15 April 2018. On six of the 2pm to 8pm shifts, there were five occasions where the third staff member left at either 6.30pm or 7pm. This meant there would be only two staff left on duty until night staff arrived at 8pm.

Staff on duty told us a staff member had to observe the communal lounge area at all times. This left one person to assist people. People's risk assessments showed that 14 out of 17 people required 'maximum support' and two staff to assist them. This meant there were times when there were not enough staff on duty to meet people's needs.

During our visit, we saw there were times when people had to wait for care. We saw one person had to wait over 15 minutes to go to the toilet until staff were available to assist them.

On the second day of our visit, the service was short of staff and the activity coordinator had to deliver care to support staff. People and staff told us this happened from time to time and had affected people's ability to have their social needs met.

Two of the three people we spoke with told us they thought the service needed more staff. One person told us, "I would like a bath or shower more often than once a week. That is what I did when I lived at home. I don't always feel as clean as I would like but I know how busy the staff are." We spoke with two relatives of the person and one of them told us, "My relative would like to have a bath or shower daily but there just isn't enough staff. I do worry about how they feel because I know they are not used to not feeling clean. I know that staff are busy and they really are, but why should my relative miss out."

We saw a 'Bath list' on the wall in the nursing office which identified that each of the 17 people using the service were assigned a day and either morning or evening slots for a bath, bed bath, hair wash or shower. Staff confirmed that this was an up to date list for people currently in receipt of care. They also told us that this was all the service could manage given the current staffing levels. We noted that this also had an impact on person-centred care as people were not able to be bathed at a time of their choosing.

Staff we spoke with said they felt the service needed more staff. One staff member told us, "It can be tight.

There are definitely not enough staff. We really struggle when there is sickness. If staff don't turn in for duty nine times out of ten we just get on with it, we run on lower numbers. The activity staff member or the laundry staff member will help out but it is not ideal. I wish we had more staff because it would just give us time to spend with people. Sometimes I feel like we are just doing for people." Another staff member told us, "We often work with only three staff during the day when there should be four. Its hard work, most people need two staff, which just leaves one to watch everyone when we are short. You stay in the lounge watching people but not able to do anything. People have to wait; it's not nice having to tell people to wait for the toilet."

We discussed our concerns with the provider who told us there were enough staff on duty. They also said they left the management of staffing the service to the deputy manager and previous registered manager. No amendments to staffing levels were made in response to our discussion with the provider. Due to our concerns about fire safety and the current staffing levels at night, we reported our concerns to the fire service. Following the visit from the West Yorkshire Fire Service, the provider increased the staffing levels at night from two to four staff. On the third day of our inspection we checked the rotas and saw these staffing levels at night time had been maintained.

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

Risks to people which related to the management of medicines and fire safety showed where the provider's lack of oversight had put people's safety and wellbeing at risk. We reviewed care records and saw staff had developed care plans and risk assessments relating to other aspects of people needs. For example, a person who required assistance with their continence needs. They had a care plan which included a detailed assessment of this risk and staff had a good awareness of it along with the actions they needed to take to support this person to maintain their safety and welfare. Staff could identify people who were at risk of falls and malnutrition or dehydration, and through our discussions with them it was clear they knew how to manage these risks.

People we spoke with told us they felt safe. They said they knew the staff well and trusted them. The relatives of one person told us they felt their relative was safe at the home and that staff were very knowledgeable. They also said that the fact most staff had worked at the service for a long time was reassuring.

There were systems in place to safeguard people from the risk of abuse. This included having both a safeguarding and whistleblowing policy and procedure in place, informing both staff and people who used the service about how they could both report and escalate concerns. The staff we spoke with were clear about what abuse was, the signs and symptoms they would look for and who they would speak with about concerns. There had been no safeguarding issues reported to us since the service was last inspected. There were systems in place for recording accidents and incidents. There had been no issues to record, other than one staff accident since our last inspection.

People were protected by the prevention and control of infection. There were appropriate procedures regarding this and staff had been trained to understand these and the importance of good hand hygiene, cleanliness and supporting people with infections. In line with best practice guidance, staff wore protective clothing, such as aprons and gloves, when supporting people and these were appropriately disposed of.

The provider completed the relevant checks before staff began working at the service to help ensure they employed people who were suitable to work at the home. Staff files included a range of documentation that

included application forms with full employment history, photo identification and written references. Disclosure and Barring Service (DBS) checks had been completed to help ensure staff were safe to work with vulnerable adults. DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council.

Requires Improvement

Is the service effective?

Our findings

The provider had not ensured that staff were appropriately trained and competent to support people safely. New staff at the service completed an induction which consisted of training and shadowing more experience staff on duty. Staff training was completed by watching a set of DVDs' on subjects including basic life support, continence care and COSHH. Staff completed a question booklet after watching a training DVD. We reviewed the training question booklet and found it did not include a check of the competency of the staff member on completion of the training. We were also unable to clarify who would check the questionnaire. Records were not available to show that staff competency had been checked in relation to completed training for any of the care staff who worked at the service.

Staff had not completed any practical aspects of fire safety training. All of the staff we spoke with told us they had not carried out a practised evacuation. The provider's 'Fire safety' policy stated, 'All staff are to receive a fire awareness and evacuation training day and staff must receive at least two training sessions per year. Night staff must receive three training sessions per year. There was no evidence to show that the policy had been followed. There had also been recommendations made in the fire risk assessment dated June 2014 with regard to staff needing to complete practical aspects of fire training. The provider had failed to address the recommendations made.

Staff training was recorded on a central matrix. We were shown the June 2018 matrix which showed 14 staff required an update with fire safety training, and seven staff required an update with safeguarding and manual handling training. There were no dates booked for the training to be completed.

Staff personnel files showed they received regular supervisions and annual appraisals. These had mainly been completed by the previous registered manager. In the absence of a manager for the service, the provider had not made arrangements to establish who would be supervising staff.

Issues relating to staffing levels reported in the safe domain of this report affected people's ability to have choice about when they had their care needs met. This included when they had baths and showers. We saw this was limited at the service due to staffing arrangements.

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

The building had been adapted to meet people's needs, including a lift and specialist bathrooms. The reception area had been developed so that people with mobility needs were able to enter and leave the building easily. Most people spent their time in one communal lounge with an adjoining dining area. There were no other quiet areas where people and their visitors could sit.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff told us one person using the service was currently subject to a DoLS. The administrator kept a file containing applications which had been submitted to the local authority which were pending. Care records showed people's capacity was kept under review, with relevant assessments held within people's care plans. Staff had good knowledge of the principles of the MCA and told us they explained people's support and care to them, gaining consent before carrying out any aspects of this. Throughout the inspection, we saw staff speaking clearly and gently with people and waiting for responses and consent where necessary, prior to delivering care. Staff understood the principles of DoLS and how to keep people safe from being restricted unlawfully. This showed staff were aware of their responsibilities under this legislation.

People's health care and support needs were assessed before they moved into the service. The deputy manager told us care plans were developed using the assessment information.

People were supported to access the healthcare services they needed and there was evidence of regular monitoring of people's wellbeing within people's care plans. The deputy manager and nurses had responded appropriately to changes in people's needs or condition. They had made referrals to other healthcare professionals when needed. People told us they had regular appointments with their GP and other healthcare services, which included chiropodists, opticians and dentists. We spoke with one healthcare professional who was complimentary about staff who worked at the home. They told us, "The staff are very organised and it is clear that people's needs are their priority. The nursing staff are good at communicating with us and following any guidance we give."

People were supported to eat and drink enough to meet their hydration and nutritional needs. People were complimentary about the food they received and said there was always a choice of meals. Comments included; "The food here is very well presented and there is lots of choice" and "Always a good choice of food and it's all homemade, it's very nice." Each person had a detailed eating and drinking assessment and care plan based on their needs and preferences. Staff were knowledgeable about people's differing dietary requirements. The cook worked closely with people and staff to identify and support people's nutritional needs. Staff were observed following guidance provided by healthcare professionals when assisting people at the lunch time meal.

Requires Improvement

Is the service caring?

Our findings

Whilst we observed staff to be caring and supportive of people on a one to one basis when delivering care, we concluded that the overall service delivered was not caring. The provider had not appropriately monitored the service and put sufficient measures in place to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result, people were not appropriately cared for. Their health, safety and well-being was put at risk due to the evidence that resulted in the breaches of regulation in the safe and well led sections of this report.

People did not receive care that was entirely person centred. This was because the provider had not arranged staffing levels to ensure people could have their personal care needs met in a timely manner, people were not always involved in the development of their care plans and relatives were not always involved in reviews of their relative's care. The provider's lack of engagement in overseeing the service had resulted in people not being appropriately cared for.

There were no details available for people relating to accessing advocacy services. Advocacy services represent people where there is no one independent, such as a family member or friend, to represent them and their views.

We recommend the provider considers current guidance on accessing advocacy services and ensures this is made available to people using the service.

People told us they had not been involved in developing their care plans. Two relatives told us they had not formally been involved in any reviews of their relative's care plans.

During the inspection we observed kind and caring interactions by staff members. Staff addressed everyone by name and spoke in a respectful manner. It was clear that staff were caring and they displayed a warm and genuine manner when engaging with people. We saw people smiling when staff approached them. Staff told us that the people using the service were very important to them. One staff member told us, "This is a hard job but I wouldn't change it. We care very much for these people and will always do our best."

People looked well cared for and were supported by staff to maintain their presentation.

People confirmed they were given privacy and treated with dignity and respect by staff. Staff were observed to knock on people's doors and wait for a response before entering people's bedrooms. Likewise, when personal care was needed, this was given in privacy either in people's own rooms or bathrooms.

People were able to personalise their bedrooms. For example, people had decorations in their bedroom which were important to them or showed their interests. For example, one person's room contained photos of their family and people who were important to them. The person told us how important it had been for them to have their own things around them. They said, "It's not home is it, but if I can have my things around me, I can feel at home."

Staff understood the importance of promoting people's independence. People said staff encouraged them to do as much as they could for themselves which helped them maintain their independence whilst providing them with help and support where needed.

Personal and confidential information relating to people who used the service was kept secure. This included hard copy files being stored securely in lockable cupboards and information held electronically was password protected with only relevant people having authorisation.

Staff had all received training in equality and diversity and there were policies in place to help ensure staff were considering people's individualised needs in the delivery of care.

Requires Improvement

Is the service responsive?

Our findings

Whilst we observed staff to be supportive of people on a one to one basis and as responsive as possible when delivering care, we concluded that the overall service delivered was not responsive. The provider had not appropriately monitored the service and they had not responded when concerns were brought to their attention by third parties or the Commission. The provider did not put sufficient measures in place to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result, the service was not responsive to people's needs. Their health, safety and well-being was put at risk due to the evidence that resulted in the breaches of regulation in the safe and well led sections of this report.

The provider had failed to meet the Accessible Information Standard and people did not always have their needs met due to staffing shortages, this included personal care and activities. The provider did not have sufficient oversight of the service provision which meant areas of people's needs were not responded to appropriately.

Some people were unable to easily access written information due to their healthcare needs. The registered provider did not have a policy in place to provide staff with guidance on the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with this standard.

We recommend the provider implements guidance for staff to follow regarding the Accessible Information Standard and incorporate this into relevant documents within the service.

People had their needs assessed before they started using the service. We saw care plans had been put in place and these were reviewed regularly or when people's needs changed. We found accurate daily records were maintained. For example, we saw up to date records were held in relation to when people had received a bath/shower, when bedrooms had been cleaned and their clothes washed. Daily records of people's care and support and their participation in activities were also held within care plans.

People gave examples of how the staff treated them as individuals and knew how to support them in the way they liked. One person told us, "They bring me a warm drink in the morning as they know I like a bit of a lie in. At night, they take their time to make sure I am comfortable before they leave me. I have extra pillows to support me in bed and the staff make sure these are set right for me."

The service employed a dedicated activity coordinator who had developed an activity plan for the service. They gave a number of examples of events recently held at the service. This included regular entertainment and activities which were planned around people's preferences. People enjoyed having the newspaper read out with some discussion and we saw this taking place on the first day of our visit. Staff told us people enjoyed quizzes and games of 'name that tune' which were also included on the plan. Records showed the activities coordinator visited people in their rooms and offered activities on a one to one basis.

Technology and equipment was sourced to assist staff to support people with physical needs. These included hoisting equipment, profiling beds and call bells. We spoke with staff about the use of technology and aids to assist people with communication needs. Staff told us there was no one currently using the service who required this level of support.

The provider had a complaints procedure in place which was displayed on the notice board in the entrance hall for people and relatives to refer to. We reviewed a complaint the service had received and saw it had been investigated as per the policy guidance, and the complainant informed of the outcome. People and their relatives told us they knew how to raise any concerns they had and felt confident that the deputy manager would deal with them appropriately. One person told us, "I have never made a complaint, I haven't had to but I would speak to the staff or the deputy, she's very good and gets things sorted." A relative told us they had contacted the administrator in the past with an issue and found them to be approachable, dealing with the issue very promptly.

People had opportunities to discuss their preferences related to their end of their life, and we saw that healthcare professionals were involved as required. The deputy manager gave examples of how the service had previously supported people and relatives, ensuring that discussions had taken place about people's preferences and choices and to make sure that people were supported with dignity and in the way they wanted. We saw consideration was given to people's spiritual and cultural beliefs and that these were respected.

Inadequate

Is the service well-led?

Our findings

There was a lack of oversight and monitoring of the service by the provider which had put people at risk of significant harm. We found they had only visited the service once in an 18-month time period previous to our inspection. The provider told us they had maintained regular contact with the service via email and telephone. However, there was no evidence to support their oversight and the concerns we identified suggested this level of monitoring was not adequate.

The provider had a quality assurance system in place which consisted of a set of monthly audits which had been completed by the previous registered manager up to May 2018. The system did not include any evidence of oversight or input by the provider. We found significant concerns relating to people's safety which had not been identified through the quality assurance system. This included medication audits which showed no concerns. We identified a range of concerns related to the premises of the service, fire safety, insufficient staffing levels and staff training and competency. This meant the system was not robust and the provider had failed to ensure people's safety.

Staff we spoke with told us the provider was not visible, or approachable and some had never met the provider. Staff told us there was a lack of presence at the service by the provider and they felt they had been left to get on with running the service for them. Staff reported feeling unsupported and not valued by the provider.

The service did not have a registered manager in post. They had left their post recently and the provider was actively recruiting for a new manager. The provider told us the deputy manager was responsible for the day to day management of the service until a new manager was appointed. We were concerned because the deputy manager had no dedicated time to perform this role. Rotas showed they were always included in the numbers for delivering care and they were also the only nurse on duty when on shift. Staff told us they were concerned there was no one to take a lead at the service and it would fall to the team to manage the service. This included covering staffing shortages, recruitment and liaising with suppliers. This demonstrated that the provider had not ensured there were suitable management arrangements in place at the service.

The provider failed to supply documents and information we requested at the time of inspection, such as the electrical safety certificate. The provider did not take appropriate action to mitigate known risks to people's safety such as those identified in the fire risk assessment report dated 2014. This meant the premises and other aspects of the service were not safe. Staffing levels were not calculated in line with people's needs and impacted on staff's ability to meet people's needs in a timely manner. Staffing levels also meant staff may not be able to assist people safely in the event of a fire. Staff competency was not checked after the completion of training, and some training did not include practical aspects. For subjects such as fire safety, checks of staff competency could not be evidenced and the provider's policy had not been followed. Staff had not completed appropriate training to assist with the receipt and administration of controlled drugs. This demonstrated the provider had failed to ensure the service met the required standards and as a result had placed people at significant risk of harm.

This demonstrated a breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff at the service worked in partnership with other organisations and professionals to make sure they were following current practice, providing a quality service and the people in their care were safe. These organisations and professionals included social services, healthcare professionals including General Practitioners and district nurses. We spoke with a health care professional who told us, "The deputy manager is very conscientious and sets high standards."

People and their relatives were invited to attend three monthly meetings to discuss the service. We saw at the previous meeting held in May 2018, discussions were held about food provision at the service, which people were happy with but some had made suggestions for new items to be included on the menu. Other areas discussed were provision of activities and upcoming events at the service. This included a visit from a donkey sanctuary, entertainers and a raffle to raise funds. The next meeting was scheduled for September 2018.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured the premises were safe. This included electrical safety and fire safety. This put people at risk of harm.

The enforcement action we took:

We took enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have robust governance arrangements in place. There was a lack of oversight and involvement of the provider which led to a number of failings within the service including; fire safety concerns, electrical safety issues, unsafe management of medicines, insufficient staffing levels which impacted on peoples safety and their care.

The enforcement action we took:

We took enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had not ensured that staff were skilled and competent in relation to fire safety procedures. Staffing levels were not sufficient to ensure people's safety, or that there needs could be met in a timely way.

The enforcement action we took:

We took enforcement action to cancel the provider's registration.