Mrs M Ghouze

The Birches

Inspection report

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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**

Overall summary

We inspected The Birches on 12 February 2016 and the visit was unannounced. We last inspected the service in February 2015. At that inspection, we found breaches of legal requirements in four areas; the reporting of incidents and accidents, assessing risk, good governance and safeguarding people who use services from abuse.

We asked the provider to take action to make improvements. They sent us an action plan that all the improvements would be in place by 31 July 2015.

On this visit we found that there were continued breaches in assessing risk, protecting people from harm, providing safe care and good governance. There were further breaches in staff recruitment, medicines administration and providing adequate infection control.

The service has a registered manager in post.

Risks to people's health and safety was not overseen, managed or reviewed. We found a number of infection control issues throughout the home.

There were not always sufficient numbers of staff to keep people safe and meet their needs.

Summary of findings

Staff recruitment procedures not adequate to ensure people were cared for by staff who had been assessed as safe to work with people.

The legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not being followed. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. The DoLS safeguards should ensure that people are not unlawfully restricted.

People's basic human rights were not fully respected, though their privacy and dignity was upheld and respected and people were called by their preferred name.

People were provided with meals that met their cultural and dietary needs. Health professional advice was not sought for all those at risk of malnutrition and dehydration.

People's care plans lacked detail about people's individual care needs and meaningful activities, but included details about people's cultural and spiritual wellbeing.

There was limited information relating to people's health needs and associated risks with diagnosed conditions.

The provider did not have effective systems in place to assess, monitor and improve the quality of care.

The provider had not appointed and registered a manager who had the appropriate skills, experience and qualification to ensure the effective governance of, and safety of those in the home.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and safety were not managed, reviewed thoroughly or updated information provided to ensure people's safety.

Medicine protocols were needed to ensure people received an effective dose of medication.

Staffing numbers were inconsistent, which did not ensure people's needs were met safely.

Staff did not go through a thorough employment or recruitment process, which was a potential risk to people's safety.

People were placed at risk from acquired infections, through poor infection control procedures.

Is the service effective?

Requires improvement

The service was not effective.

People signed to agree the care offered in their care plan, though staff could not ensure they acted legally when obtaining people's consent.

Staff did not fully understand the requirements of the Mental Capacity Act to ensure people's capacity.

There was inconsistent recording between care plans, daily records and accident report information, which meant staff may not have had up to date information about people's care needs.

Monitoring of medical interventions and health care services were not undertaken robustly to protect people from harm.

People were provided with meals that met their cultural and dietary needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

People did not receive a consistently caring service, through a lack of planning and intervention.

People were spoken with in a compassionate and were addressed by their preferred name or title.

People's privacy and dignity was upheld and respected.

Is the service responsive?

Requires improvement

The service was not responsive.

Summary of findings

Pre-admission assessments and care plans did not identify people's individual care and support needs.

People were offered a varied diet and specific dietary requirements were confirmed by healthcare staff.

People's healthcare was not properly assessed or planned for, which meant people were placed at risk from staff who were not properly informed.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not arrange for the registered manager to ensure an effective overview of the home and to take action as needed.

Effective systems were not in place to assess, monitor and improve the quality of care.

People were not protected from a poorly maintained environment.

Policies and procedures that were in place had not been reviewed regularly and did not reflect the current best practice or the changes in the law that governs health and social care services.

The Birches

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 12 February 2016, and was unannounced. The inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the home and information from the local authority commissioners.

We had not received any notifications from the provider since they were registered with us. A notification is information about important events which the service is required to send us by law.

During the inspection we spent time observing the care being provided throughout the home. 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 three people using the service, a visiting relative, the registered manager, two care staff, cook and cleaner.

We looked at records relating to all aspects of the service including care and staffing, as well as policies and procedures. We also looked in detail at three people's care records and the recruitment files of three care workers.

Inadequate

Is the service safe?

Our findings

We looked around the home, and in one area found a non-permeable floor covering with a strong odour of urine. We informed the registered manager who told us the area still had to be cleaned. When we returned the odour had decreased, though was still apparent in the carpeted area in the corridor outside the bedroom. That meant the fire door was the only barrier stopping the odour of urine infiltrating the lounge area. We also found areas in toilets, kitchen, and laundry which did not allow proper cleaning and disinfection. That meant that there was potential for cross infection and cross contamination in the home.

We saw that personal protective equipment (PPE) was available throughout the home, and staff used this at appropriate times. That meant that staff were able to protect people that lived in the service and each other from the risk of cross infection.

We looked at the storage cupboard for cleaning materials which was appropriately locked. There were adequate supplies of cleaning materials, though the cleaner on duty was not familiar with the control of substances that are hazardous to health (COSHH) processes and the safety around handling chemicals safety. They told us there were no COSHH data sheets to refer to in case of an emergency. That meant people were placed at risk of chemicals being used or handled inappropriately. We could not locate a COSHH policy and procedure which could be used to guide or instruct staff to ensure peoples safety.

Staff were able to tell us about the coloured mop heads, which areas of the home they were used in and how they were stored and disinfected. However these were being stored inappropriately and did not reduce the potential for cross infection and cross contamination in the home. We also noted there was not an adequate policy, procedure or definitive guidance for staff that ensured the process was carried out safely or consistently. That meant that people were not protected from the spread of infection in the home.

This was a breach of Regulation 12 (2) h of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of unsafe care or treatment and transfer of infections.

We checked whether the management of medicines was safe and found shortfalls with the management of medicines. People in some instances had been prescribed PRN medicine (medicine that is taken as and when needed). We found that there were no clearly written PRN protocols in place and staff were unclear what medicines were PRN and which weren't. That meant there was potential for people not to receive their medicine in a consistent manner as there was no clear guidance for staff to follow.

When we spoke with staff they were also confused about the administration process. We were unable to locate a policy and procedure for medicines administration, though this was supplied to us following the inspection. This was not detailed enough to ensure that staff had clear instruction and administration procedures were consistent.

We identified that open dates of medication had not been recorded by staff. This meant that people could have been at risk of receiving out of date medicine.

Staff sometimes used at code to state that a medicine had not been administered. However, they did not always record the reason why people had not received the medicines. In addition, there were gaps in the recording of administration of some people's medicines. That meant that it was not always possible to ascertain whether people had received the medicines as planned.

We also found that there was no signatory sheet in place. That meant that we could not be assured which member of staff had administered the medicines.

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

We found risk assessments were reviewed with each care plan review. However this was a tick system and did not indicate the risk had been reviewed and updated to ensure people's safety. There were no associated detailed risk assessments to identify control measures and ways to reduce the risks identified. That meant risks to staff and people who used the service had not always been identified and assessed appropriately.

For example we found that a person who was being cared for in bed. There were no risk assessments in place to reflect the time they now spent isolated in their room. However we did find the 'Personal Handling Risk Assessment' which stated [named person] 'requires hoisting, but we don't have a hoist upstairs'. This risk

Is the service safe?

assessment did not clearly mitigate the risk posed by the person's immobility. We were told by the registered manager this person was unable to weight bear, and staff had been unable to ensure an approximate weight. We asked the registered manager about this, they stated they had not made any referral to the district nurse or nutritionist to assist with this process. That meant people were at risk of being malnourished through lack of staff intervention and planning.

We found another person had five falls in one seven day period and accident reports were completed on each occasion. However the risk assessment had not been updated to reflect the changes and increase in falls. That meant that people's safety could not be ensured as staff did not understand how to protect people appropriately.

The provider had failed to make sure that risk had been thoroughly assessed to protect people from harm and ensure their safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's care plan files did not reflect current and significant risks such as risks associated with known health conditions, reduced mobility or falls. Staff who were working in the home had a limited understanding of what these risks meant for their practice and how to ensure people's safety. We found that the care staff had not been provided with any support to develop the skills needed to complete appropriate risk assessments around these types of behaviours and conditions. The registered manager told us that the senior staff wrote and reviewed the care plans and risk assessments. But we found there were no effective checks in place to ensure all the support a person required was reflected accurately, included in the care plan or risk assessed properly. That meant people were at risk from care that was not risk assessed properly.

The registered manager told us that restraint was not used within the service. During the inspection we found that a person was being cared for in bed, and bed rails had been attached to the bed, the registered manager told us this was for the person's safety. They also told us the decision had been made by the person's relative, even though the person has capacity and told us they did not want them placed on the bed. Staff did not understand the difference between lawful and unlawful restraint. This had not been recognised by the provider and no action had been taken to make sure that people were safe from the use of unlawful restraint. The CQC reported these concerns directly to the safeguarding coordinator at the local authority.

The provider failed to make sure people who used the service were safe from the risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a consistent recruitment process in place to ensure people's safety. We looked at three staff recruitment files. There was no proof that two people had references from their previous employer. That meant the provider did not have a system in place to ensure that staff remained safe to work with people.

The provider failed to make sure people employed by the service had the appropriate clearances and checks in place prior to commencing employment. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were three care staff members on shift in the morning, two or three in an afternoon, and one waking and one sleeping in member of staff overnight. There was also a cook, housekeeper and laundry assistant employed on a daily basis.

We spoke to the staff regarding the staffing numbers in the home. They were concerned about the staffing numbers in an evening as the normal staffing was two people. One member of staff said they had suggested the use of agency staff, to allow three staff on an evening, but the provider had refused. That meant at these times, people were placed at risk of not being observed or assisted with personal care in a safe way.

People using the service who were able to give their views told us they felt safe at the home. One person said, "I feel safe here." We also observed people throughout the day, who were relaxed in the presence of staff. However we found people were not safe in the home due to the combination of poor care planning, lack of detailed risk assessments and absence of essential equipment.

Most of the people who used the service were not able to tell us if they felt safe. Some of the people who lived at the service had limited communication so we were unable to

Inadequate

Is the service safe?

obtain direct verbal feedback about their experiences. We made a number of observations throughout the inspection which has informed this report. We saw that people were relaxed when staff entered rooms.

Staff knew how to recognise the signs of abuse and were able to tell us what the different types of abuse were. Staff we spoke with were able to explain the different types of abuse and the action needed if they suspected abuse had taken place. Staff knew about the safeguarding protocols and processes for reporting abuse to external agencies such as the local authority or police. Staff were also aware of whistleblowing, and who they could contact with information of concern. That meant staff had the knowledge to report on any safeguarding or potential abuse to the appropriate external body such as the local authority.

Staff were aware of the whistleblowing procedure and all staff spoken with said that they felt they could raise concerns with the registered manager, or the provider when they saw them.

Individual personal fire evacuation plans had been completed and each person had an individual assessment to identify what support they required in case of an emergency. For example if they required to be evacuated from the building. We looked at the plans, some of which had not been updated to reflect people's up to date needs, and noted they were stored in the ground floor office. That meant the plans were not readily available to ensure people were handled safely in an emergency. We asked the registered manager about how the person that was in bed would be evacuated from the first floor. They stated the person would be evacuated whilst being strapped in a mattress, however there was no suitable equipment to allow this type of evacuation.

We noted that the Fire Officer had visited in July 2015 and made some recommendations to ensure people were safe in the home. We saw that these had not all been completed, and referred these issues back to the appropriate fire authority for them to follow up.

We spoke with the registered manager who assured us safety checks had been undertaken throughout the home. On the first floor landing we noted there was a window with a very low sill. Windows with a low sill height require to be risk assessed to inform people in the service and staff of any danger. There was no risk assessment in place, which meant that people's safety was potentially put at risk.

When we spoke with staff they shared concerns regarding the numbers of staff available to assist people when they required two staff. They explained that in an afternoon and evening there were not enough staff to ensure people remained safe, and provide care to someone in their bedroom. We spoke to the registered manager about this and they said they would again approach the provider for additional staff to ensure people were safe at all times.

Requires improvement

Is the service effective?

Our findings

At our inspection of February 2015, we found provider did not ensure people were asked to consent to the care and treatment offered to them.

This was a breach of Regulation 11 (1) (3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us a plan that they would be compliant by 31 July 2015. At this inspection we saw these actions had not all been completed and the provider was still in breach of this regulation.

We saw that consent forms had been introduced for areas such as staff administering medicine, personal care, sharing information and taking photographs. These had been signed by people, though it was not clear if they had capacity to do so. We found two people who had bed rails in place on their bed, one of whom was being cared for in bed. One person told us, they did not consent to bed rails being placed on their bed, and they did not want them there. The registered manager told us they were placed there for the person's safety, and agreement was sought from the person's relative, as the person had fluctuating capacity. There was no policy or procedure to regulate how consent was obtained. That meant staff could not ensure they acted legally when obtaining people's consent.

This is a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that records were not being completed consistently by staff. For example, one person had several falls which had been recorded in the accident book, however there was no reference to the incidents in the person's daily notes or in any part of the care plan. That meant that essential information could potentially get lost which could put people at risk or ensure they were effectively supported. The registered manager was unaware there were no complimentary records in the people's daily records and did not think this was an issue.

People's care records showed that they had not been supported to attend medical appointments. We found where one person required regular intervention and monthly visits to the hospital to receive special injection. Staff had recorded the person was 'too ill' to attend hospital and cancelled the appointment. This could have resulted in the person going blind. Neither the provider nor registered manager had made any attempt to report this to the GP and seek an alternative treatment. Following our visit contact was made with the GP and an alternative to the hospital visits was arranged.

We also found where a GP had arranged for an x-ray of a person's finger. The information on the form explained it may have been trapped in some equipment. However we found that the person had not been taken for the x-ray, nor had there been any follow up with the GP. Staff told us the person refused to attend the appointment, however this was no written record or explanation about the reasons why. That meant the person had not had the arranged x-ray or any subsequent treatment, and had remained in pain. We followed this up with the registered manager who stated they would inform the GP.

This is a breach of Regulation 12 (2) b of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager and staff about anyone who had been granted a restriction under the Deprivation of Liberty Safeguards (DoLS). The registered manager made us aware of a person who was restricted from leaving the building for their safety. The provider had failed to inform us through the appropriate notification process this had been granted, and this was being monitored by staff from the local authority.

We also found that there was other person who had their liberty deprived, by the use of 'bed rails' which restricted the person getting out of bed. Neither the provider or registered manager had recognised this, and made an assessment of the persons capacity, or the appropriate DoLS referral to the local authority. There had been no best interests meeting convened for this person. That meant that the decision was being made for people without adhering to legal principles and deprived people of their liberty.

We looked at the two policies on restraint of people in the home, and one for the use of bedrails. These did not include the proper process or information to ensure people were treated and cared for appropriately. That meant there was a failure by the provider and registered manager to monitor and protect people from the improper use of restraint.

Requires improvement

Is the service effective?

The Mental Capacity Act (MCA) 2005 is legislation used to protect people who might not be able to make informed choices on their own about the care and support they receive. At this inspection we found that staff did not understand the requirements of the Mental Capacity Act 2005 and had not recognised they were restricting someone's liberty or recognised the best interests' principles.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC reported these concerns directly to the safeguarding coordinator at the local authority so that these could be investigated appropriately and any follow up actions be put in place.

The registered manager and staff told us they were unaware of the principles of the MCA and DoLS. We asked to look at the training matrix for the staff group to ascertain the level of staff training for the MCA and DoLS. This was not available on the day, and was not sent to us, as requested following the inspection, so we are unable to confirm any MCA or DoLS training the staff had undertaken.

We found most people's weights were measured and recorded though these were not always up to date. Where concerns about people's food or fluid intake had been identified, some had been referred to their GP and other medical professionals such as dieticians and speech and language therapists. However we found that one person who had seen their GP had an outcome where the staff were to 'push fluids'. There was no goal on the monitoring charts, to inform staff how much fluid the person required. None of the charts we saw were totalled. That meant staff were unable to assess and report any progress or decline in the person's condition.

Information in care plans detailed people's dietary needs and people were provided with meals that met their cultural and dietary needs. For example in one file was saw the person required a fork mashed diet. Some people were also referred to healthcare professionals to ensure the appropriate dietary information. That meant staff had the appropriate information on people's dietary requirements.

We spoke with people about food and nutrition and one person said, "I enjoy my lunch, the cooks good. Another person said, "Usually, I get what I want."

We observed the lunch time meal and saw most people were eating independently though staff were on hand to support. We saw that people appeared to enjoy the food provided. The dining experience was well organised and we observed that people were supported appropriately. Those that wanted fish and chips were given a choice of three different types of fish. The cook asked people whether they wanted "white fish, scampi or salmon." One person couldn't make a choice and asked for all three types of fish, the staff gave them some of each. Another person asked for help to cut up her food and a carer supported their request. Staff offered apron's to people in order to protect their clothing. Some wore aprons whilst others chose not to. That meant people were provided with choice and their privacy and dignity was promoted.

There was no supervision policy to indicate how often supervision should take place. The registered manager told us she planned staff supervision every two months, but was not currently meeting that target. Previously supervision was completed by senior care staff, who observed staff completing tasks such as medication administration and report writing. The registered manager had planned dates of supervision in advance but had no specific programme to adhere to. We looked at a selection of staff supervision records which did not include detailed discussion about people who lived in the home and how the care they received could be developed. That did not demonstrate supervision was targeted towards developing the care people received.

Staff told us that they received regular supervision and they thought that these sessions were useful in providing a good service. The registered manager told us that she had no management qualification in care and limited experience of delivering care to people in a residential setting.

The registered manager also told us she did not receive supervision from the provider, but had regular visits from the provider's representative.

Requires improvement

Is the service caring?

Our findings

People told us that they liked the staff and felt that they were well cared for. A visiting relative said, "[The] care staff are fantastic, and they look after mum very well."

However we found occasions where people had not received care that met their basic human rights. We found there was one person with a degenerative eye condition, who had not attended their appointments and this had not been followed up with their GP or consultant. We found where another person had refused food and drinks. However this had not been brought to the attention of their GP or further health professional assistance sought. We also found there were people who had bed rails in place. They were not given the choice or their capacity assessed to ensure the least restrictive options. One person told us they did not want the bed rails in place. Staff told us the person had varying capacity but had not arranged a best interests meeting or explored any less restrictive practice. We saw where the staff offered people their mid-morning drink but when people asked for an alternative of tea, they were told this was not available but no explanation why. This does not demonstrate a caring service.

We observed staff interactions with people throughout the inspection which showed that staff were caring and helpful. Staff demonstrated patience when supporting people to allow them to maintain a pace that was comfortable for them. For example, we saw a person being helped to mobilise from a wheelchair into the lounge. The staff gave instructions to the person and allowed the person to move at their own pace. We also observed care staff sitting with people in communal areas and prompting them with activities of a floor game. They interacted well with people, and also engaged people in conversations. That demonstrated that people were treated in a respectful way.

We observed a carer who had just commenced their shift, and greeted people in a friendly manner to which they responded positively. We later confirmed this was done using their preferred term or title, which demonstrated people were spoken with respectfully. One person asked the carer to help them to the toilet. The carer supported this person to do so but clearing the way for them to walk and walking by the person's side. That demonstrated staff were responsive to people's requests and assisted people in a thoughtful and compassionate way. Two other carers came in with a person whom they were assisting to sit on one of the arm chairs. Staff were talking positively to the person and explained clearly what they were doing for example, "turn around [person's name], walk back two steps, slowly sit," they were also guiding the person with their hands. That demonstrated staff knew how best to communicate with people.

Records showed that family members had been involved in care plan reviews, people's religious beliefs were recorded and their current activity with their religion was also noted. We saw there was information in care plans to ensure people were referred to by their preferred name.

We saw that there was no information regarding independent advocates available at the service. An advocate can assist people who have difficulty in making their own, informed, independent choices about decisions that affect their lives. We discussed advocacy with the registered manager who confirmed that this information would be made available to people. At the time of our visit nobody was using the services of an advocate.

Throughout our visit we saw that people were able to make choices about how and where they spent their time. We observed staff knock at the people's bedroom doors before entering. We also saw when staff were attending to people they closed the door. That meant staff recognised people's privacy and dignity.

Staff we spoke with told us they encouraged as many people to maintain their independence as long as they were safe to do so. Throughout our visit, we saw staff encouraged people to make their own decisions and prompted them to move around independently. That meant people's independence was promoted.

Requires improvement

Is the service responsive?

Our findings

At our inspection of February 2015, we found provider did not ensure that care was being planned and delivered to meet people's individual needs. This is a continued breach of Regulation 9 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, which took place on 12 February 2016 we found the service still did not have personalised care plans in place.

The provider sent us a plan that they would be compliant by 31 July 2015. At this inspection we saw that the provider had not completed all of the actions and was still in breach of this regulation.

We looked at three people's care records and found the format of the care plans had changed. All the files included a photograph, pre-admission assessment and the areas of care that the person required support with. Some had information missing and others did not include personalised information about people's individual needs and preferences. For example what specific care needs they had, such as how often they should be turned in bed. We asked staff about this, they were unsure and quoted the care plan timing of two to four hours. Staff were clearer on peoples allergies to foodstuffs and another to certain anti-biotics. There was little evidence of people's personal life history and experiences, which is valuable in planning appropriate and meaningful activities to support people's diminishing health.

We found there was one person with additional needs and staff were completing monitoring charts for areas such as food and fluid intake, turning charts weight and behaviour. Fluid monitoring charts were not totalled, and there was no 'target' for staff to aim for. Some of the totals we saw were as low as 400mls in any 24 hour period. However there was evidence this information may have been incorrect as the staff did not use a consistent regime to record information. For example we found where a document to record continence wear was also temporarily used to record when a person was turned in bed. That meant there were inconsistencies with staff recording which placed people at risk from lack of detailed care recording.

We looked at pre-admission assessments which are used to gather information about peoples support needs prior to admission. The document that was used was a 'domiciliary care needs assessment'. This document covered the person's name [previous] address, next of kin details and GP details. There was information on the persons care needs prior to moving into the home, however this was based on their domiciliary needs in the community and did not cover all the areas on which to base a care plan for residential care.

We saw there were health action plans included within the care plans but these were not up to date and did not reflect people's current needs. For example we found the staff had not been able to record one person's weight as we were told the person could not stand and bear their own weight. Neither the provider nor registered manager had recognised this, and attempted to make alternative arrangements to enable the person to be moved and handled safely. There was no evidence of a physiotherapy referral being requested through the GP. We asked the registered manager why they had not referred this person to have their mobility needs assessed. They answered that, "It was the person's choice they stayed in bed", and had not recognised they had any additional needs. That meant that people's health was placed at risk as staff did not have up to date information about their individual needs.

Following the inspection we referred this person to the local safeguarding authority. The outcome of their visit directed the staff to contact the appropriate health professionals as they had not done so following our visit. That was to ensure that the specific needs of the person were assessed and they were cared for safely.

Turning charts were in place as the person was being cared for in bed. The care plan stated the person was to be 'turned 2-4 hourly'. The recording on the charts was inconsistent, and none we saw reflected a turning regime of 2 or 4 hourly turns. We could find no evidence a health professional had been contacted to ensure the appropriate turning regime to ensure this person's skin integrity remained intact. That meant the person was at risk of developing pressure areas.

Weight monitoring was being recorded as 'unable to weigh as bedbound', so staff had been unable to do this for four months. That meant it was not possible to ascertain if the person had lost or gained weight, which made it difficult to establish if the person was at nutritional risk. Food intake was recorded inconsistently, with individual meals being recorded as 'eaten or refused' though no amounts were detailed. The GP had been informed of the person's poor

Is the service responsive?

nutritional intake. However the last four monthly care plan reviews stated 'monitor food and fluid and GP will consider prescribing supplements.' There was no evidence that the GP had been given regular updates on the person's nutritional intake. That meant the person was at risk of being malnourished and losing weight due to poor recording and staff inaction. That in turn could also impact on the person's skin integrity.

Behavioural charts were being completed as one person presented with behaviour that challenged. However there was no corresponding information in the care plan about deflection techniques or how staff could diffuse challenging situations. That meant people were placed at risk from lack of individual management techniques to regulate excessive behaviours.

Most sections in the care plans had been reviewed on a monthly basis. However, most reviews recorded no change. On the times there were changes there was no record of any discussions taking place or any signature to suggest the person had been involved in the review of their own needs. That meant people did not have the opportunity to be involved or agree the care they were offered.

This is a continued breach of Regulation 9 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people during the inspection and one person said, "I like to read poetry; I don't like watching TV so I sit here."

We spoke with a visiting relative who explained her relative chose the home because it was "homely." They also said, "The staff are lovely and my mum has made some good friends." And added "My mum loves the cat, and the cat loves her. She [her mum] gives her [the cat] biscuits."

We observed the staff playing a 'Ludo' game with a number of people in the main lounge. The game was new and staff appeared to be confused how to play the game or give clear instructions to the other people that were playing. We saw that staff included all those in the lounge in the game or engaged them in conversation about the how the game should be played. There was an activities board on display in the dining room, however there were no actual activities planned for or displayed on the board.

We spoke with the previous activities coordinator who advised they had recently left the position due to other commitments but went on to explain that they used to play cards with people at the service. We spoke with a visiting relative about activities. They explained that they visited their relative most days and played cards with them.

We also observed people being served drinks. We observed that two people had asked for coffee, however neither person was given coffee and the staff explained, "I only have tea." Both people then agreed to have the tea that was offered. That did not promote people's individual choice.

We saw minutes of meetings for people in the home, some of these included people's relatives. That gave people the opportunity to provide their views on the home. We saw that people had been consulted about mealtimes and the menu choices, and changes made to the meal choices. That demonstrated that people's opinions were taken into consideration.

One person said, "There are sometimes meetings, they're minuted, and they also come to us [about changes]." They also said, "If I had any problems, I'll speak to the staff."

We spoke with a visiting relative who told us, "They recently changed and swapped the dining room and lounge around as no one really liked it the other way."

There was a complaints procedure displayed outside the ground floor office. We asked the registered manager if there had been any complaints since our last visit. They indicated there had been two formal complaints; however one turned out to be a complaint against patient care at a hospital, and should not have been included in the record. The other was investigated and resulted in disciplinary action against staff. That meant there was evidence the service effectively responded to people's concerns, investigated complaints and took appropriate action to deal with concerns. We looked at the complaints policy and procedure, which did not include details of the local authority, who are the appropriate body to investigate complaints.

Inadequate

Is the service well-led?

Our findings

At our inspection of February 2015, we found the provider had failed to make sure quality assurance and good governance systems were in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, which took place on 12 February 2016 we found the service still did not have systems in place to assess and monitor the quality of service provision.

The provider sent us a plan that they would be compliant by 31 July 2015. At this inspection the provider had not completed all of these actions and was still in breach of this regulation.

We spoke with the registered manager about what governance had been introduced since our last inspection in July 2015. We looked at the monitoring system for cleaning and disinfection of toilets. These were a 'tick' system, but were not backed up by a cleaning schedule, or instruction how areas should be cleaned and disinfected, or the chemicals to be used. There were also some audits of the medication system and care plan audits however these were again a simple tick system. There was no evidence produced of any regular audits being undertaken. Audits are one way management can check and record that standards are being maintained. They also provide a record of any action taken to improve standards.

We also noted with closer scrutiny and review of documents and premises audits people have not been protected from a poorly maintained environment. The registered manager told us she did a 'daily walk round', but did not formally record environmental checks. We saw there was a repairs book in place, however this did not provide an appropriate means of assessing, monitoring or mitigating risk in the home.

We looked at the recommended changes made to the building following a visit from the fire officer. Some of these had been implemented, however changes to the staff sleeping in had resulted in the fire officer recommendations being negated. There were also other changes that had to be implemented to ensure all the recommendations were completed. That meant people were placed at risk from a building which had not been fully improved. We reported our findings to the fire authority to follow up.

Staff told us they had regular meetings, however the registered manager could not find the minutes from these meetings. We asked for copies following the inspection however these were not produced. This meant there was no way of checking what actions or changes staff had been instructed to implement. This does not demonstrate good governance by the provider or registered manager.

The provider had not arranged for the registered manager to ensure an effective overview of the home and take action as needed. Overall we found a number of issues which had not been picked up by the provider's audit systems. That meant that quality assurance was not systematically monitored or detailed enough and the audit systems in place were not effective or used to drive continuous improvement. That did not demonstrate a well led service.

The provider had failed to make sure quality assurance systems were in place to ensure that risk had been thoroughly assessed to protect people from harm and ensure their safety. This was a continued breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the provider issued questionnaires to people using the service and relatives on a six monthly basis. We looked at the returned questionnaires, which provided detailed comments about the home. Many were positive, such as 'good home' and 'homely'. However we noted there were comments to ask where the alterations to provide a 'wet room' which had been on hold for over 18 months. We asked the registered manager about this, who stated following the service user meeting where the subject had been raised, the quotes had been obtained. However the provider had not authorised the expenditure. That meant the provider was not responsive in following up comments and providing updated equipment which had been agreed.

We looked at the policies and procedures. These had not been reviewed recently, and many were out of date and did not reflect the current best practice or the changes in the law that governs health and social care services. We found the provider and the registered manager had not kept their knowledge up to date or accessed information from experts or other agencies about best practice and changes

Inadequate

Is the service well-led?

in regulations. For example there was no mention in the policies or procedures with regard to the Human Rights Act, MCA or DoLS legislation. That meant people may be detained unlawfully in the home.

The registered manager told us there was no planned supervision of her by the provider, but added the provider's husband was in the home most days of the week. We could not find a policy about staff supervision. That meant there was no guidance for people where they could expect supervision and development were planned and executed to assist the flow of information and drive change in the home.

The registered manager also told us she has no formal management qualifications, and was employed in a domiciliary care setting prior to commencing this post. That meant the registered manager had little depth of experience and relied on the provider to drive change, something which they failed to undertake.

It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that a service displays their most recent rating. On the day of our inspection we saw the rating from the previous inspection from February 2015 was on display outside the ground floor office.

Prior to our inspection visit we contacted the health care professionals involved with the people who used the service. Until recently the local authority had not contracted or commissioned a service from the home. The information we received indicated there were no contracting issues prior to our visit.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider had failed to ensure care was being planned and delivered to meet people's individual needs.** Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider had failed to make sure that risk had been thoroughly assessed to protect people from harm and ensure their safety.** Regulation 12 (2) a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People had not been supported to attend medical appointments.** Regulation 12 (2) b

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had failed to ensure proper instructions were in place to enable medicines to be administered accurately and at appropriate times.** Regulation 12 (2) g

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure that people had been protected cross contamination or cross infection from acquired infections. Regulation 12 (2) h

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not safeguarded from abuse and improper treatment. Regulation 13 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not established and operated effectively to ensure compliance with the requirements. Regulation 17 (1) (2) a

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 failed to make sure people employed by the service had the appropriate clearances and checks in place prior to commencing employment. Regulation 19 (1) a