Homestead Residential Care Limited

Hanwell House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
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?	Requires improvement

Overall summary

The inspection took place on 28 and 29 September 2015 and was unannounced. At the last inspection on 14 August 2014 we found the service was not meeting the regulation relating to staff supervision and appraisal. At this inspection we found that some improvements had been made in the required area, however the provider was still not meeting the legal requirement fully. We also found areas where new breaches were identified.

Hanwell House is a care home which provides accommodation and personal care for up to fifty two people. Nursing care is not provided. The service specialises in the care and support of older people, some of whom are living with the experience of dementia. At the time of our visit there were 44 people using the service. The home is run by Homestead Residential Care Limited. The registered manager is also a director in the company.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People and their relatives told us they felt the service was safe. However we found that the service was not safe. Fire safety arrangements were not being followed and this placed people at risk in the event of a fire.

People were at risk of receiving unsafe or inappropriate care because staff did not understand what constituted abuse and the reporting procedures to follow in the event of a safeguarding alert.

Risks to people were not fully assessed and management plans were not always in place to minimise these risks. This placed them at risk of harm. There was no effective system in place to ensure information about accidents and incidents could be analysed so appropriate action could be taken to prevent them from happening again and to monitor for any trends or patterns.

Staff were not always recruited safely to make sure they were suitable to work with people who needed care and support.

Staff had not received the appropriate training, support and appraisal in order to carry out their roles effectively and to an appropriate standard, this meant that people were at risk of receiving unsafe or inappropriate care.

The service was not fully meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The majority of people at the service had their liberties unlawfully restricted. The provider's systems of ensuring that the service enabled people to consent to care and treatment in line with legislation and guidance had not been effectively implemented.

People and relatives said the staff were caring. However, we found that people were not always supported by caring staff. Some staff did not speak with people when they were supporting them. For example, we saw some people being supported with their meals in a way which was not dignified or respectful. We saw other staff that were kind, caring and treated people with dignity and respect.

Care plans were not always in place regarding all the care needs people had and they were not person centred. There was no evidence as to how people, or their families or representatives, had been involved in the development and review of the care plan. People had limited opportunities to participate in meaningful activities or hobbies that were important to them

People were not protected against the risks of poor care and treatment because the provider did not operate an effective system to assess, monitor and improve the quality and safety of the service. The systems in place had not identified the shortfalls we found.

People lived in a dementia friendly care home environment which promoted their wellbeing and independence. Furniture, color schemes and lighting had been chosen in line with best practice guidance.

People received their medicine safely and by staff that had been trained.

People were supported to maintain good health and had access to health care services when they needed it.

People enjoyed the food and were provided with a variety of food to choose from. Staff monitored people's weight and referred them on for specialist support, when they were concerned about their risk of malnutrition.

People, relatives and staff spoke positively about the registered manager. They said the registered manager was supportive, caring, and visible around the home and always made themselves available to discuss any issues or concerns people had.

We found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Fire safety arrangements were not being followed and this placed people at risk in the event of a fire.

People were not always protected from avoidable harm or potential abuse because the staff did not fully understand their responsibilities.

Recruitment practices were not robust. Not all of the relevant checks were carried out before staff began work to ensure people were safe.

There was a lack of effective risk management to ensure the safety of people, staff and visitors to the home.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had not received the appropriate training, support and appraisal in order to carry out their roles effectively and to an appropriate standard, this meant that people were at risk of receiving unsafe or inappropriate care.

The service was not fully meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The majority of people at the service had their liberty unlawfully restricted.

People were supported to maintain good health and had access to health care services when they needed it.

People's nutritional needs were assessed and they had a variety of food to choose from.

Is the service caring?

Requires improvement

The service was not consistently caring.

People and relatives spoke positively about the care they received.

People were not always treated with respect and dignity by some staff. However, we saw some other care practices that were kind and caring.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Care plans were not always in place regarding all the care needs people had and they were not person centred.

People and their relatives/representatives had not been involved in the development and review of their care plan.

Summary of findings

People had limited opportunities to participate in meaningful activities or hobbies that were important to them.

People's needs were assessed prior to them moving into the home by the manager to ascertain whether the needs of the individual could be met by the service.

The provider had systems in place to respond to complaints about the service.

Is the service well-led?

Requires improvement

The service was not consistently well- led.

People were not protected against the risks of poor care and treatment because the provider did not operate an effective system to assess, monitor and improve the quality and safety of the service. The systems in place had not identified the shortfalls we found.

The manager knew all the people at the service and had a 'hands on' approach. The manager was approachable and supportive to the people at the service, their families and the staff.

Hanwell House

Detailed findings

Background to this inspection

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

This inspection took place on 28 and 29 September 2015 and was unannounced. The inspection team consisted of two inspectors. Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed any other information we held about the service including notifications.

During the inspection we observed care and support in communal areas. To do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also observed interaction between people using the service and staff throughout the inspection.

We spoke with ten people using the service. We spoke with the registered manager, administrator, three team leaders, seven care staff and four relatives. We viewed eight people's care records and a variety of records relating to the management of the service including medicines management, staff records, audit findings, finance records and health and safety records.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person said "Its fine. The staff are very nice and kind." Another said "There is nothing untoward." All the relatives we spoke with told us they visited regularly and had never seen or heard anything that gave them concern about people's safety. Comments we received included "She is so well looked after. I am totally confident that she is safe and happy here", [relative] is very, very safe. I have no worries at all" and "I have never felt that [relative] is unsafe here."

Although people told us they felt safe we found that risks to people had not always been managed safely or recorded appropriately.

We spoke with seven members of staff about their knowledge of safeguarding. Three staff were able to tell us about the different types of abuse that people could experience and the procedures they would follow to report it. All of them said they would raise any concerns they had with the manager. Only two out of the seven staff knew which external agencies to contact if they needed to. Comments from staff included "I don't know who else I would tell outside. I would not ignore it" and "whistle blowing, I am not sure what that means." Four other staff understood the questions that we asked them about safeguarding but were unable to articulate a response to us in English. No information was displayed regarding safeguarding and what people or their families could do to contact the local authority safeguarding authority if they wanted to. This meant that people were at risk of receiving unsafe or inappropriate care because staff did not understand what constituted abuse and the reporting procedures to follow in the event of a safeguarding alert.

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

People were at risk because staff were not able to tell us about the fire evacuation procedures they would follow. Two out of the seven staff were able to tell us about the fire procedure. The other staff we spoke with found difficulty in understanding the questions we asked regarding fire safety and how they would keep people safe. Fire drills had been carried out, however the records completed were brief in detail. For example one record did not detail the time of the evacuation, in another two records we saw that there were no details of the evacuation carried out.

There was no evidence of personal emergency evacuation plans (PEEPs) for all people to assess and plan how they would escape in the event of a fire, and to ensure that appropriate fire safety measures were in place. We saw that a fire risk assessment had been carried out in March 2013 by an external company. Action was required to address issues with the external fire escape. When we asked the manager whether the action from the fire risk assessment had been addressed, they told us it had not been. On the first day of our inspection we saw that the fire exit in the ground floor lounge and on the first floor dining room were obstructed. The provider's daily health and safety checks did not include checking the fire arrangements. Both exits were made accessible during the inspection when we raised this with the manager.

The provider had not carried out risk assessments in relation to building works that were taking place in the home. They told us all bedrooms that were being refurbished were locked and could not be accessed by people using the service. Risk assessments to ensure the safe use of bedrails had not been undertaken for the two people living at the home for whom these were used to prevent them falling from bed.

We saw that people did not have access to call bells when alone in their rooms and we asked staff about this. Staff explained that many people living at the home were not able to use call bells and had pressure sensitive mats by their beds which alerted staff to them moving about. These mats were extensively used and when tested we saw that care staff responded promptly to an alert. However, we saw that two people who used bedrails who had not been provided with an alternative means of calling for assistance.

Accidents and incidents were recorded appropriately, detailing the support people had received and any other action taken by staff. However, we found that there was no effective system in place to ensure information about accidents and incidents could be analysed so appropriate action could be taken to prevent them from happening again and to monitor for any trends or patterns.

The majority of people at the service were living with the experience of dementia. Some had behaviours that challenged and physical healthcare needs. Our general observations were that staff communication was poor. The majority of staff did not have English as their first language. Nine of the care staff had not had training in dementia care.

Inadequate

Is the service safe?

Some staff did not understand the questions that we asked them about how people were supported with their care, safeguarding or fire evacuation procedures. One relative told us "You can't always understand what the staff say, it's not a problem, they are good." A staff member said "Language is a major problem here, there are some you can understand and others you can't. It must be frustrating for people." This meant that people were at risk of receiveing unsafe care and treatment because the provider had not ensured that staff had the competence, skills, qualifications and experience to care for people.

The above paragraphs showed there was a lack of effective risk management to ensure the safety of people, staff and visitors to the home.

The above were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always recruited safely to make sure they were suitable to work with people who needed care and support. We viewed recruitment records for two new staff. Application forms had not been fully completed. Employment histories were not detailed and there were unexplained gaps with no written evidence to show that these gaps had been questioned. References had been obtained but both application forms did not provide referee details. Both staff had been subject to a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observation was that despite seven care staff and one team leader on duty, that they were rushed, meals were very late and we observed three people were not offered any food or drink between the hours of 8.30am and 10.50am when their breakfast was served to them in their rooms. The food trolley for people on the second floor who ate in their own lounge did not arrive until 9.45am by which time most people had been expecting breakfast at 9.00am. One person told us "I get up about 4 or 5am. I don't get a cup of tea until the trolley arrives." In the main dining room we saw that staff were rushed and people sat for up to forty five minutes before they were served any breakfast. We observed two care staff at different tables who sat between two people and attempted to support them to eat their meals at the same time. One person got up after eating their porridge telling us they could no longer wait for their cooked breakfast. They had been waiting thirty minutes.

The manager told us that staffing was based on a measurement of each person's dependency, which determined the number of care staff required for each shift. They said there had been no reduction in staffing and 44 people were using the service and they would review how staff were deployed and allocated.

Where the service supported people with their money we saw that arrangements were in place to manage this safely. Receipts were kept for all expenditures and records kept. Monthly reconciliations were carried out by the administrator and where required information was submitted to the local authority.

Other risks to people had been assessed, such as moving and handling, falls, nutrition and where appropriate the risk of pressure sores. Where risks were identified the staff were provided with guidance about how to minimise the risk of harm. For example, care records identified the types of pressure relieving equipment such as cushions and mattresses that people required. Where people required bed rest as part of their pressure sore risk management, this was recorded in the care plans. Care plans also recorded the type of equipment to be used to keep people safe stating the type of hoists to be used to assist people needing these and the number of staff required when using this equipment. We saw people being supported with their moving and handling by two staff as required.

Staff were kept informed of the risks that people faced through the use of a colour coded easy to read spread sheet which was available to all staff in the office. The information included which people required pressure relieving equipment, weight monitoring, food and fluid monitoring and the different types of nutritional supplements people had. However, whilst we saw that risks to people had been identified it was not clear whether they were regularly reviewed and updated.

We saw people being supported to take their medicines. The service used a weekly blister pack system, which minimised the risk of dispensing errors by staff. We saw that instructions for the administration of medicines were clear and printed Medicine Administration Records (MAR) were available. When people's medicines were administered this

Inadequate

Is the service safe?

was recorded on the MAR. Medicines were checked when they were received into the service and the pharmacist provided a clear description of each tablet that had been dispensed. Weekly medicines checks were carried out and records maintained to ensure that people had received their medicines as prescribed. Where people had medicines that were to be administered as required (PRN), clear guidelines were not always available. However we saw that people's care plans briefly described when the medicine was to be given. For example, we saw this in the care plan for a person who experienced agitation. Records showed people had regular blood tests if they took certain medicines whose side effects should be monitored. This helped protect them from associated health risks. Staff we spoke with had appropriate knowledge of safe medicines practice. They had regular competency based training in this area.

People lived in a clean and well maintained environment. People's bedrooms, bathrooms, toilets and communal areas were clean. We saw that staff used appropriate protective clothing when supporting people with their personal care. Hand sterilising units were available throughout the building and these were regularly replenished. One staff member told us that special training had been arranged for staff immediately following the admission of a person with a blood related disorder. Training records confirmed this.

Requires improvement

Is the service effective?

Our findings

People were cared for by staff who did not always receive appropriate training and support.

At our last inspection in August 2014, we found that people were cared for by staff who were not always fully supported to deliver care and treatment safely and to an appropriate standard. Staff did not have the opportunity to have their performance reviewed through an appraisal. Following the inspection the provider sent us an action plan detailing how they would make improvements. At this visit we found that some improvements had been made in implementing staff supervision. An appraisal system had not yet been implemented. The provider said they were aiming to have all annual appraisals completed by April 2016. Where staff had received supervision records were maintained. Three staff we spoke with confirmed they had supervision. There was some evidence that staff meetings took place, however these were not regular and staff told us the main form of communication was through the daily handover meetings. The manager told us he spoke with staff daily and ensured they visited every floor several times throughout the day so he was aware of what was happening in the service.

Staff did not receive a structured induction when they started work. This meant that people were at risk of receiving ineffective care. On the first day of our inspection a new member of staff had been paired to work with another more experienced member of staff. Another staff member had been working at the service for two weeks and told us their induction programme had involved shadowing an experienced member of staff during this period. All three of these staff had not been provided with training on fire, safeguarding or moving and handling. The manager told us they would have received moving and handling training from one of the team leaders. None of the team leaders were qualified to provide this training. We saw from training information provided that only nine of out of twenty six staff had undertaken moving and handling training. The manager told us that training was provided by an external company throughout the year and training had been planned for the new staff to complete their induction over a twelve week period.

The above showed us that the provider had not ensured care staff had received appropriate training and appraisal to enable them to carry out their role effectively.

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

We asked staff about the training they had undertaken. They told us the quality of the training was good. One staff member told us “the training here is real training – not just watching a film. For example we attend a course on manual handling where we practice using the actual equipment and hoists.”

People who could tell us about their care said that they were happy to live at the home and with the care provided. People also indicated that they could get up and go to bed when they chose. Four of the people we spoke to said that they were not able to leave the building when they wanted to. One person when asked whether they were able to leave the building said “you are not able to go out without a carer” and was content with this due to their concerns about their mobility. Another person was not happy that they were not able to go to the park across the road. They said “I am not allowed to cross the threshold. There is a park just across the road. I would like to get to it. I am not allowed to go out alone. And there is no one here to take me.” This person used a wheelchair but said that they were able to manoeuvre themselves the short distance required. Another person said “I never get to go outside.” We saw that there key pads on each floor preventing people from leaving the areas in which they lived. One person living on the second floor told us they were not allowed to leave the floor without permission.

We asked the manager about how people’s capacity to make decisions about their care was assessed and were told that “most people living at the home do not have capacity”. They told us they and the staff had undertaken training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The front door, first floor and second floor were kept locked with numerical keypads to ensure people did not leave without support. This was because staff had assessed people as being unable to safely leave the premises without support. However, people’s capacity to make these decisions had not been assessed.

Staff told us people lacked the capacity to consent to the restrictions on their liberty but there was no evidence that the provider had carried out assessments of mental capacity to confirm this was the case. The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) state that where people are deprived of their liberty,

Requires improvement

Is the service effective?

certain processes must be followed and recorded. These include assessing people's capacity to consent to restrictions, planning to review restrictive measures on a regular basis and considering ways in which people's needs can be met in the least restrictive manner possible until the relevant authority has approved any deprivation of liberty. At the time of our visit only five people had a DoLS authorisation in place, this meant that where applications had not been made to the local authority for people they were being unlawfully restricted. Bedrails were in use for two people, as they were at risk of falling out of bed. Their capacity to consent to this decision which had led to a restriction on their liberties had not been assessed. One person had been refusing their medicines regularly, the records for this person said they had no capacity. We found that no action was taken in their best interests about this. The service was therefore not always acting in line with legislation and guidance.

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

We saw do not attempt resuscitation (DNAR) orders had been assessed by the GP, where appropriate with the person and their family members in their best interests. These are decisions that are made in relation to whether people who are very ill and unwell would benefit from being resuscitated if they stopped breathing.

People's nutritional needs were assessed and monitored. People told us they enjoyed the food. Established staff had a good understanding of people's needs and their preferences had been recorded, such as whether they had a pureed diet, normal diet or whether they liked specific foods only. People's weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake. The provider was piloting the use of different coloured plates and bowls in line with good dementia care practice. Staff told us this enabled people with difficulties with their sight and perception to be better supported with their food.

People's health and welfare was monitored and they were referred to external healthcare professionals and services as required. For example, we saw that regular blood glucose monitoring was carried out by staff for a person that had diabetes. We saw people had received input from other healthcare professionals including a GP, district nursing service, dentist, optician and podiatrist, to ensure their healthcare needs were being met. Records also showed that people were supported to attend hospital appointments with a member of staff, and the outcomes of any visit were recorded in the daily records. The service also carried out routine urine testing for two people and where required anticipatory antibiotics were administered in discussion with other healthcare professionals.

People lived in a dementia friendly care home environment which promoted people's wellbeing and independence. Extensive refurbishment work was in progress and plans were in place for each person to have an en-suite shower room. The majority of people had a low rise dementia bed to reduce the risk of people falling out of bed and the need to use bedrails. Wardrobes and chests of drawers with easy to use openings were in use and new color contrasting armchairs had been purchased. Each bedroom door had a memory box for people to fill with personal items for reminiscence and to help navigate them to their room. Shower heads changed color so that people could see whether water temperatures were hot or cold and specialist lighting was available throughout the home. Each floor had an up to date large board providing information about the day, date, a picture of the season and the weather which helped orientate people. Clocks displaying day and night time symbols were also in people's rooms and in communal areas to enable people to distinguish between day and night.

Requires improvement

Is the service caring?

Our findings

People told us they thought staff were kind and caring. We saw many positive interactions between staff and people, for example we saw staff playing traditional music for a person who was agitated and staff reassuring a person that was anxious. One person said "Yes I am happy here. Staff are always good. Never angry. You can choose what you eat. Absolutely." Another said "It's a great place and staff are nice." Relatives comments included "There are no improvements required here, I'm not bluffing. Everything is good. And "I feel lucky to have got [relative] into this home."

We saw other interactions which showed that people did not experience care and support that was respectful and maintained their privacy and dignity. For example we saw a domestic member of staff supporting a person with their breakfast. They did not speak with the person the entire time. We saw one care assistant sat between two people and attempted to support them both at the same time. There was little interaction with either person and at one point the carer left the table without explanation. Porridge was given to three people in a glass instead of a bowl, people had no choice about whether they had jam or marmalade on their bread.

On another occasion we saw a person's trousers falling down as they walked and the carer kept them up by pulling the belt loop from behind. It was only after we spoke to the carer that they thought to get the person's trouser braces and put them on. At mealtimes staff placed protective aprons on people without asking or explaining what they were doing. People were given drinks without being offered a choice of what they wanted. We saw that one person was dressed but lying asleep on their bed, the door was open, with their lower body exposed. They remained in this position between 8.30am and 10.50am when breakfast arrived. This meant that people's care was not delivered in a way that respected people and ensured their privacy and dignity.

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

We observed some care practices which upheld people's privacy and dignity. For example, care staff always knocked before entering someone's bedroom. Personal care was provided in the privacy of people's bedrooms and the doors shut, some people had keys to their bedroom. People made choices about whether they spent their time in their bedrooms or one of the communal lounges.

People were included in their care. We saw staff talking with people and seeking people's permission before carrying out any support for example, staff wanted to support a person with their mobility by using a hoist. The person refused to give permission and staff respected this. Relatives we spoke with said they were they were kept informed about changes in their care family member's care and condition.

People were supported to maintain relationships with their families and friends, for example we saw that a person was supported to call their family once a week. Three relatives told us they were regular visitors to the home and that staff always made them feel welcome.

Requires improvement

Is the service responsive?

Our findings

People and relatives we spoke with were satisfied with the standard of care provided in the home. One relative told us "[relative] is so much calmer since they moved here, [relative] is very well looked after." However, we found that the provider did not always ensure people had comprehensive care plans that reflected their needs. Therefore, there were risks that people might not receive the care they required.

People's needs were assessed prior to them moving into the home by the manager to ascertain whether the needs of the individual could be met by the service. We looked at eight care records, these detailed people's preferences in relation to their daily routines, the name they preferred to be called by, their usual preferred time for getting up and going to bed, the use of equipment and number of staff required to move people and details about their personal care requirements.

We found that although care plans contained information about people's needs they were not comprehensive, provided only brief guidance to staff and there was little information about people's backgrounds and histories despite some people having been at the home for a long period of time. For example, one person's care plan made no mention of a person's first language being Greek despite this being their preferred language. For another person, the care records stated they could be in pain when they moved and no pain assessment or care plan was available. We checked the person's medicine record and saw that regular pain relief was offered. We saw that a person had been refusing medicine for more than two weeks. Staff told us, this person required medicine in a liquid form. We found that staff had not followed this up with the GP or the dispensing pharmacist until we raised it as a concern with them. No care plan or risk assessment was in place for managing a specific medical condition a person had.

We asked staff how they knew what support and care people needed. Staff who had worked at the service for a while knew a lot about people. Newer members of staff did not know people well. Three staff said that information about how to care for each person was passed from one member of staff to another and that they had not read people's care plans. This meant that people may not be given a choice about their care on a day to day basis because options were not presented to people. There was also a risk that if information was not verbally passed on important aspects of care would not be provided.

We saw dates on people's care plans which indicated they had been completed recently. However, we noted the contents of the plan were clearly written early on in people's stay as incidents and dates from up to eight years old were referenced in the plans of care. There were no evaluations or reviews of the care provided although aspects of people's health including weight and blood pressure were monitored regularly. One relative told us that meetings did take place to review their relatives care although they were not invited to be part of this meeting. There was no information as to how people, or their families or representatives, had been involved in the development and review of the care plan.

The care plan for one person, who was diabetic, recorded they could be offered puddings, biscuits, cakes and sugar in their tea, appearing to not take account of the person's diabetes. This meant that either the person was not being supported appropriately with their diabetes or that the care plan was not based on accurate, up to date information.

People had limited opportunities to participate in meaningful activities within the service or in the community that were based on good practice guidance. Comments we received from people included "I do cross words and like reading. But I don't know what others who can't do so much do whilst here." And "I rarely go out and I would like to be more energetic. There is not enough to do." People's interests, choices and preferences in relation to activities had not been recorded and care plans only referred to the needs of people to be involved in activities. We saw people sitting in the ground floor lounge with nothing to do and very little interaction from staff. There was little occurring to stimulate or engage people. A bingo activity session took place late in the afternoon on the first day of our visit. A mass service was held at the home and six people attended. Some people spoke about a dancing session which was held fortnightly. Some people had daily newspapers. We spoke with the manager who told us that it was the responsibility of the care staff to carry out activities. There was a large board in the main entrance informing people of the activities available in the home on

Requires improvement

Is the service responsive?

each day. We discussed these findings with the manager who said they would make the necessary improvements by reviewing the information in the care plans and appointing to a designated activity co-ordinator role.

The lack of comprehensive guidance and plans of care for identified needs meant that people were at risk of not receiving an individualised service.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that staff were responsive to changes and situations arising concerning people's day to day care, for example calling an ambulance for a person following a seizure. Where people had behaviours that challenged, care plans provided staff with instructions about how to support the person in this area and the possible triggers for the behaviour such as a urinary tract infection. For example, care records for one person showed investigations had been carried out to test for an infection when behaviour that challenged had been observed.

The manager had identified that care records did not contain information on people's life history. They showed us the work they had started on this area so that staff would be better able to support people as individuals.

People we spoke with told us they would speak to the manager if they had any issues or concerns. Relatives we spoke with said they would feel confident any complaints would be responded to. The manager told us they had a procedure for making complaints. No complaints had been received by the home since the last inspection.

Requires improvement

Is the service well-led?

Our findings

People and relatives told us the home was well managed. Comments we received from relatives included "He seems to be here all the time, he is a good man, he walks around and will take the time to chat with you" and "He is totally aware of everything that is going on, he is fully hands on and honestly I would give them 10/10."

People were not protected against the risks of poor care and treatment because the provider did not operate an effective system to monitor and assess the quality of the service, so areas for improvement were identified and promptly addressed. Where actions had been identified to make improvements these were not always completed. For example, a recommendation made in the last fire risk assessment in 2013 by an external company had not been addressed. An external pharmacy audit was carried out in May 2015 and recommendations were made in relation to the disposal and recording of variable doses of medicine. These recommendations had not been addressed. The findings in this report and the number of breaches of regulation we found showed that the systems were not effective in identifying areas where people might have been at risk so that the provider could take the appropriate action to protect people. Regular checks were carried out on medicines, money managed on behalf of people and health and safety checks. The manager acknowledged that the quality assurance system was not robust.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulations 2014).

The provider was also the registered manager. They spoke with passion about providing a good quality of life for the people at the service. They told us "I want to care for people in the way that I would want my family to be looked after. I always tell the staff when you have helped someone go to bed in the evening, always say "goodnight", you may be the last person to have contact with them."

People, relatives and staff spoke positively about the registered manager. They said the registered manager was supportive, caring, and visible around the home and always made themselves available to discuss any issues or concerns people had. Staff told us the manager provided good leadership. One member of staff said "I find him to be very good. He has a wonderful attitude and is very caring towards the people here." Another staff member said "He thinks about the residents and tries to bring in new ideas that will improve their lives, such as the memory boxes. He is here all the time." They also told us the manager promoted a positive culture that was open and transparent.

There was a management structure in place which included the manager and four senior carers. There was no deputy manager position within the structure. We saw that the manager had a very "hands on" role and knew the people at the service very well. However, we found that the manager took responsibility for all aspects of service delivery. Little was delegated to the senior carers. Relatives and staff told us he was at the service "all the time." We asked the manager who provided cover when they were on leave. They told us they did not take leave. There was not a clear management structure in place to ensure people's care needs were always being met in a consistent and safe way. Day to day responsibilities were not defined for the manager and care staff so that people's care was compromised. We discussed these findings with the manager who said they would review the management structure, roles and responsibilities and staff deployment to make the necessary improvements.

People and their families were asked for their views about their care and support and they were acted on. A survey was sent to people and their representatives to obtain their views of the service. We saw the findings from the latest survey in August 2015, the results of the survey were very positive. The manager told us information from the surveys was used to help improve the service, and an action plan would be drawn up if shortfalls were identified.

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 (RA) Regulations 2014 Person-centred care People who used services were not protected against the risks of receiving care and treatment that was inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs, achieving service user's preferences and ensure their welfare and safety. Regulation 9(1)(a)(b)(c)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected. Regulation 10(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. Regulation 11(1)(2)(3)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users because the registered person had not assessed the risks to the health and safety of service users and doing all that is reasonably practicable to

This section is primarily information for the provider

Action we have told the provider to take

mitigate any such risks and ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Regulation 12(1) and (2)(a) (b) and (c)

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 Systems and processes were not established and operated effectively to prevent abuse of service users. The provider had not ensured that people were deprived of their liberty for the purpose of receiving care or treatment with lawful authority. Regulation 13(2)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not ensure that systems or processes were operated effectively to ensure compliance with the requirements in this Part. This includes assessing, monitoring and improving the quality and safety of the services provided in the carrying on of the regulated activity, assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity and maintain an accurate, complete and contemporaneous record in respect of each service user and the management of the regulated activity. Regulation 17 1)(2)(a)(b)(c)(d)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have suitable arrangements in place in order to ensure that persons

This section is primarily information for the provider

Action we have told the provider to take

employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal. Regulation 18(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 registered person did not operate effective recruitment procedures in order to ensure that no person was employed for the purposes of carrying on a regulated activity unless a full employment history, together with a satisfactory written explanation of any gaps in employment. Regulation 19(1)(3)(a), Schedule 3 (7)