Barrington House Limited

Barrington House

Inspection report

Rye Road
Hastings
East Sussex
TN35 5DG

Tel: 01424422228
Website: www.barringtonhousecare.co.uk

Date of inspection visit:
16 March 2017
21 March 2017

Date of publication:
19 May 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

Barrington House provides accommodation for up to 26 people with learning disabilities. There were 17 people living at the home at the time of our inspection. The home cared for younger adults and older people. However, most people were over 65 or close to this age group. People's needs were varied and included support with general age related conditions. Some people had more specialist needs associated with dementia, diabetes, autism and epilepsy. Whilst some people could tell us their experiences of living at Barrington House, others had complex communication needs and required staff who knew them well to meet their needs. We observed that people were happy and relaxed with staff.

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 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.

At our last inspection in August 2014 we issued a requirement notice in relation to staff levels between 6-8pm. We received an action plan from the provider that told us how they would make improvements. At this inspection we found that although records did not show that there was always sufficient staff on duty, all staff confirmed that this was the case.

On the first day of our inspection we assessed that people's dignity had been compromised. People's hairbrushes were not clean and toothbrushes did not look as if they had been used. There was no effective system in place to monitor that people's oral hygiene needs had been met. During our inspection new hairbrushes and toothbrushes were bought and by the second day of our inspection there was a new system to monitor daily that people's hairbrushes were cleaned and that people's oral hygiene needs had been addressed.

We identified further areas that required improvement. Some of the staff team had not received appropriate training to meet people's needs. This was particularly evident in relation to specialist training for diabetes, dementia and epilepsy. Although staff felt supported on an informal basis the systems for ensuring staff received regular supervision were not always effective.

Some staff did not have a clear understanding of the Deprivation of Liberty Safeguards (DoLS) and whilst they knew some people had a DoLS in place or that one had been applied for, they were not clear about others. (A DoLS is used when it is assessed as necessary to deprive a person of their liberty in their best interests and the methods used should be as least restrictive as possible).

There was a lack of risk management in terms of fire safety and ensuring that people who needed support to leave the building in the event of a fire could do so safely. Risk assessments did not always included detailed information. For example, there was no advice in one person's care plan about how staff should support the person if they displayed behaviours that challenged.

There was a lack of individual assessment and planning to ensure that some people's recreational and social needs were met and there was a heavy reliance on the use of TV as an activity. When activities were provided they were not always recorded so it was not possible to accurately assess the numbers and types of activities available.

There was a lack of monitoring in place to identify that record keeping in many areas such as staff training and supervision, staff rotas, care plans and health and safety documentation were accurate and up to date. Some matters such as menus, and monitoring of personal care had been identified as areas to improve but the monitoring systems that had been put in place to address these areas had not been effective.

Despite these shortfalls people told us they were happy with the care they received. Staff were kind and caring and they had developed good relationships with people. There was a very relaxed and calm atmosphere in the home and staff had a good rapport with people. Bedrooms had been personalised to reflect the people's individual tastes and interests. People were supported by staff who knew them well as individuals and they were able to tell us about people's needs, choices, personal histories and interests. A relative told us, "The staff are so pleasant, they can't do enough for you," and "I know I can go away and he is completely safe and well looked after." A staff member told us, "I'm very happy here, it's a lovely place to work."

Whilst there were safe procedures for the management of medicines there was no formal system in place to assess staff competency before allowing them to give medicines. People had access to healthcare professionals when they needed specific support. This included GP's, dentists and opticians. Where specialist healthcare was required, for example, from a community nurse, arrangements were made for this to happen.

Appropriate checks had taken place before staff were employed to ensure they were able to work safely with people at the home.

We found some 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Systems for ensuring the management of risks to people were not always effective.

There were enough staff employed to work in the home to meet people's needs safely.

There were safe systems for the management of medicines.

Recruitment procedures were in place to ensure only suitable people worked at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). However, not all staff knew which people had a DoLS in place.

The systems for ensuring all staff had the knowledge and skills necessary to carry out their roles were not effective. There was a lack of monitoring to ensure that staff attended regular supervision meetings and felt supported in their role.

People were supported to attend a range of healthcare appointments.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity had not always been maintained.

People's bedrooms had been personalised to their individual tastes.

Staff knew people well and displayed kindness and compassion

when supporting them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no system in place to ensure that some people's social and recreational needs had been fully assessed and plans put in place to meet them.

People's care plans were not always accurate and up to date.

People knew who to speak with if they had any concerns or worries.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of accurate and up to date record keeping and quality monitoring systems were ineffective.

Statutory notifications were submitted to the Care Quality Commission when appropriate.

Barrington 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.

The inspection took place on 16 and 21 March 2017. The inspection team included three inspectors.

Before our inspection the provider had completed 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. We reviewed the information we held about the home, including previous inspection reports. We looked at notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with six people who lived at Barrington House. A number of people who lived at Barrington House were unable to verbally share with us all their experiences of life at the home because of their learning disabilities. Therefore the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff and watch how people were being cared for by staff in communal areas. This included the lunchtime meals. We also 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.

During the inspection we reviewed the records of the home. These included three staff files, staff recruitment, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises. We also looked at four support plans and risk assessments along with other relevant documentation to support our findings.

During the inspection, we spoke with six staff members including the registered manager, care manager and assistant care manager. In addition, we requested feedback from healthcare professionals who had contact with people living at Barrington House.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2014 the provider was in breach of Regulation 22 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010, which now correspond to Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not enough staff on duty between the hours of 6-8pm. Following the inspection, we received an action plan that showed that staff levels had been increased. At this inspection we found that although rotas did not show that there was always three staff on duty, all staff confirmed that this was the case.

People told us they felt safe. A relative told us, "There are enough staff and I know I can go away and he is completely safe and well looked after." One person told us, "When I press my buzzer, they do come quick." When asked about how staff supported them with moving we were told, "They use a hoist to lift me. It's ok, they know what they are doing."

Strategies to mitigate identified risks were not always appropriate. One person had been assessed as having behaviours that challenged. However, there was no behavioural support plan to guide staff on the actions they should take if certain behaviours were displayed. Within daily records there was reference to a recent incident where the person had been verbally abusive to two people and had attempted to assault staff. There was no investigation or incident report to describe the incident and how it had been managed. Risk assessment documentation had not been updated as a result of the incident. This left the potential for staff not having the information required to provide appropriate care to people and had the potential to leave people and staff at risk of harm.

Although we observed staff using safe and appropriate moving and handling techniques we also saw inappropriate techniques used to reposition one person at the dining table. Staff used an underarm lift to reposition the person. This had the potential to cause injury to the person and to staff. We spoke with the registered manager about this and they stated that all staff had received training on how to support people with moving and this should not have been done. They said they would reaffirm this with staff and carry out assessments to monitor and ensure safe techniques were used.

Systems for the care and support of people with diabetes were not always safe. One person's care plan stated that they should receive a diabetic diet. Their daily notes regularly referred to them having a pudding and biscuits. We discussed this with staff who confirmed that this would mean a diabetic pudding and diabetic biscuits. However, this had the potential to be misleading for new staff and could leave the person at risk of harm. Although the care plan stated what actions staff should take if the person's blood sugars were low there was no information about what to do if they were high. There was no advice about what was a normal blood sugar for them although staff told us that it would be normal for them to have a high blood sugar. On one occasion records showed a higher than average reading. However, there was no record that any action had been taken by staff to reduce the blood sugar. We asked a staff member if it was their practice to retest blood sugars later if a high reading was taken. They said "No, if it was too high they would report it to the monitoring nurse." However, this had not been done on this occasion. This has the potential to leave the person at risk of harm.

Systems for the management of fire safety were not consistently effective. Within some of the care plans it stated that people should remain in their bedrooms should the alarms sound until fire fighters arrived. If they were in another part of the building when alarms sounded, staff should make sure the fire doors were closed. If there was time to evacuate, staff should transfer them to a wheelchair and evacuate. We discussed with staff that it was the home's responsibility to evacuate people in the event of alarms sounding. Given the number of people who required two staff to support them in the event of a fire staff could not be sure if this could be achieved safely and speedily in line with the home's procedure. This could potentially slow an evacuation and place people and staff at risk. Regular fire drills were carried out and showed how people responded when the alarms sounded. People who required two to one staff support were not evacuated. Drills were not routinely evaluated in relation to how staff responded. Fire alarm tests and checks of emergency lights had been carried out on 13 January 2017. There was a gap in records then until 8 March 2017. We were told that the maintenance man had been on leave during this period. However, there was no system to ensure that these checks were carried out in their absence and this had the potential to leave people at risk of harm.

Systems for the monitoring of equipment to ensure they were serviced at regular intervals were not effective. Equipment checks had last been carried out in November 2016. These included checks on stand aid equipment, mattresses, wheelchairs and electric beds. We were told that the checks were in terms of cleanliness, working order and any actions taken if faults were noted. The servicing of the stand aid was two months overdue and the servicing of the electronic hoist was two weeks overdue. We were told that this was an oversight and would be addressed. However, not having systems to check that equipment is serviced at regular intervals has the potential to lead to equipment failure and the service not being able to meet people's needs safely.

The above areas are a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were enough staff to meet people's needs safely. Staff told us that they were able to meet people's individual needs safely. The rotas indicated that were between four and seven staff on duty in the mornings, three to four in the afternoons and a waking and sleep in staff member at night. We were told that the rotas did not accurately represent the staff levels between the hours of 6-8pm.

Staff recruitment checks were undertaken before staff began work at the home. This helped to ensure, as far as possible, only suitable people were employed. This included an application form with employment history, references and the completion of a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults. This meant the provider had checked that staff were of suitable character to work at the home.

Medicines were stored, administered, recorded and disposed of safely. People's medicines were stored in a locked trolley that was stored securely when not in use. Any excess stock was stored in a separate locked cupboard. There was detailed advice on how each person should be supported to receive their medicines. People's medicines were reviewed annually by their GPs. Staff with responsibility for giving medicines had completed training on medicines.

Staff had an understanding of different types of abuse and told us what actions they would take if they believed people were at risk. All staff had received training in safeguarding and were able to tell us that if an incident occurred they reported it to the management team who had responsibility for referring the matter to the local safeguarding authority.

Requires Improvement

Is the service effective?

Our findings

There were good systems in place to ensure people attended a range of healthcare appointments. A relative told us, "If I have had concerns about my relative's health, the management have been very approachable." They also told us, "The food is good, I'm always offered meals." People told us the food was good.

At the time of our last inspection we assessed that the lunchtime experience for some people had not been a sociable experience and that improvements needed to be made. The registered manager told us that following the inspection they reviewed the lunchtime experience and made a number of changes. However, people did not like the changes made. At this inspection whilst staff served people their meals, one staff member stayed in the dining room to support one person with their meal. The atmosphere in the dining room was flat and there was little interaction between staff and people. The registered manager said they would review the procedure again in an attempt to create a more positive experience for people.

There was a four week menu that was varied and well balanced. We were told that menus had been discussed with people to ensure preferences were met. People confirmed they received food that met their individual choices and wishes. Staff told us there was a choice of main meal offered each day and that people were asked daily for their preferred choice but that this was not recorded. However, it was not evident that people had a choice of meal as the probing of food records indicated that each person had the same meal each day. One person said, "We used to get a choice but we don't anymore. If I don't like it they will boil an egg or something." On the day of our inspection the cook told us that they knew people's preferences. One person did not like the macaroni cheese and bacon that was on the menu and they were offered an alternative choice. Although the menu showed that tomatoes would be served with the main meal there were no vegetables served. The registered manager confirmed that vegetables should be on the menu daily and said that they would look into why this had not been the case.

Records showed that half of the staff team had completed training on the Mental Capacity Act 2005 (MCA) and 75% of staff had completed training on the Deprivation of Liberty Safeguards (DoLS). The care manager told us that all staff would complete this training. Staff told us people would be able to consent to basic care and treatment, such as washing and dressing. Staff were able to describe MCA principles and some of the areas that may constitute a deprivation of liberty. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. There was information within care plans about how each person communicated their needs and wishes and staff were able to clearly describe how each person made their needs known. Staff knew that if people were unable to make complex decisions for example about medical treatment a relative or advocate would be asked to support them and a best interests meeting held to ensure all proposed treatments were in their best interest. One person had given informed consent to the use of a wheelchair and lap belt.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether conditions on authorisations to deprive a person of their liberty were being met and appropriate documentation was in place. We were told that a number of standard authorisations had been applied for. However, staff did not know which people had been assessed as needing an authorisation. One staff member was not sure what DoLS meant. Staff did not have all the information they needed to understand why some people had restrictions in place and this left the potential for some people to have been unnecessarily restricted.

The above areas are a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We were told that records related to staff training were not accurate. It was therefore not possible to determine if staff had completed all the training required for their role. In relation to essential training such as moving and handling, safeguarding, food hygiene, first aid, management of medicines and infection control records showed that between one and three staff needed to compete training and there were no records for some staff. The registered manager could not be sure that staff had received appropriate training and there was no system to ensure they were competent in their roles.

We asked management what additional training staff working at Barrington House would need to complete in order to work effectively. They stated training in dementia, epilepsy and diabetes. Records showed that only eight staff had completed training on dementia. However, some of the staff listed as not having received this training confirmed that they had done so. At least half of the staff team had completed training on epilepsy. In relation to dementia, only two staff were shown as having completed this training and one of these was due a refresher. Eleven staff had been identified as requiring this training. Only three staff had received training on record keeping and on caring for people who had behaviours that challenged. Whilst it had not been possible to determine how accurate the training records were it was evident that a number of staff needed further training to fulfil the duties of their role.

There was a structured induction programme when staff started work at the home. This included time to get to know people, to read their support plans and to shadow other staff. An in-house induction checklist was completed to ensure that staff knew the home's procedures. We were told that during the induction period staff would complete the home's mandatory training. In relation to one staff member recently employed, records did not confirm that they had completed moving and handling training. As this staff member worked on night duty this was classed as essential training. The registered manager told us that it was it was their understanding that this training had recently been completed with a previous employer but the records did not confirm this. A staff member who started work in September 2016 and who worked in a non-caring role had not completed training in five of the eight areas identified for their induction training. The lack of training in these areas had the potential to place people at risk of harm.

A new system of supervision/appraisal had been introduced since January 2017 but only four staff had attended these meetings. Computer records for 2016 were not accurate so it was not possible to assess if staff received regular supervision. Records showed that some staff had attended up to three supervision meetings in 2016. Records for one staff member showed they had received supervision three times in 2015 and none in 2016. We asked this staff member if they had attended a supervision meeting in 2016 and they confirmed that they had attended one supervision meeting in 2016. The staff member told us staff did see the records but they did not sign them and did not receive a copy of them. Staff told us that they felt supported by the management of the home. One staff member said, "We have supervision meetings every three months and we discuss issues in terms of work and training. Another staff member told us that

management were, "Always approachable." Whilst some staff felt supported, a lack of regular supervision meant that there was no formal system for monitoring that staff had received appropriate training and were competent in the duties they performed.

We recommend that the registered provider introduces systems to monitor that staff have received appropriate training and support and are competent to fulfil the duties of their role.

By the second day of our inspection a number of staff had been signed up for a six week course on diabetes and the manager stated that all staff would complete this. The manager confirmed that staff would also complete training on the principles of working with people with learning disabilities.

Everybody had a health action plan. These identified the health professionals involved in their care for example the GP, occupational therapist or dentist. They contained important information about the person should there be a need to go to hospital. People were supported to attend a range of appointments to meet their individual health needs. A chiropodist visited the home regularly to provide ongoing treatment.

Requires Improvement

Is the service caring?

Our findings

A relative told us that the best thing about the home was that, "The staff are so pleasant, they can't do enough for you." They also said that, "It feels homely when you come in." Staff told us that they respected people's privacy and always asked people if they wanted them to stay with them or leave to deal with their own personal care. A staff member said, "I treat people with respect and how I'd treat my own family." Despite these positive comments we observed practices that did not indicate that people's dignity was always respected.

People's hairbrushes were dirty and toothbrushes were new and unused, or had dried toothpaste attached. Daily records showed that personal care had been provided but did not specify the particular tasks carried out. On the ground floor outside the main bathroom there were a number of hairbrushes and electric razors in a drawer. We were told that people often had their hair dried in this area. There was no way of knowing which hairbrush or razor belonged to which person. This demonstrated a lack of dignity for people. By the afternoon of our first day of inspection new hairbrushes and toothbrushes had been bought for each person and the hairbrushes had been removed from the drawer on the ground floor. By the second day of our inspection a new tick box sheet had been introduced that included daily checks that people's personal support (including specific tasks such as oral hygiene) had been carried out.

Two people sat in wheelchairs at the table. In both cases the wheelchairs could not be positioned close enough to the table for them to easily eat their meals. A staff member positioned a cushion behind one person in an attempt to bring them closer to the table and although this helped slightly it was not totally effective. We were told that new wheelchairs had recently been ordered for both people and that it would be possible to position the new chairs to the table more effectively.

On the first day of our inspection there were strong odours in a number of bedrooms. By the second day of our inspection we were told that a new steam cleaner had been bought and several areas of the home had been cleaned and this would be ongoing.

One person's bedroom had torn wallpaper in several areas. Minutes of residents' meetings showed that the person had asked for their bedroom to be redecorated in February 2017. We were told that this room was second in line to be redecorated. On the second day of our inspection the registered manager confirmed the first room was almost completed and they would then start the decoration of this person's room. Whilst progress has been made during our inspection, improvements are still required.

We recommend further support is provided and the effectiveness monitored to ensure people's dignity is promoted at all times.

People were however treated with kindness and compassion. There was a very relaxed and calm atmosphere in the home and staff had a good rapport with people. Bedrooms had been personalised to reflect the people's individual tastes and interests. People were supported by staff who knew them well as individuals and they were able to tell us about people's needs, choices, personal histories and interests. We

observed that staff talked and communicated with people in a way they could understand.

People's likes and dislikes were referred to within the care plans and there was some guidance that was very specific to people. For example, in one person's care plan it stated that the person 'Likes the light to be left on when they go to sleep." In relation to other people it stated the specific type of music they liked to listen to and that they made the decision about when they went to bed and what time they got up. This ensured that staff had information needed to support people in a way that suited them.

Requires Improvement

Is the service responsive?

Our findings

One person told us that they liked to go out every day. They said, "I decide where I want to go and how I'm going to get there." A staff member told us, "We try to make sure people are happy and enjoying life as much as possible." Whilst a small number of people led very active lives, a number of people had lost motivation for activities and there was a lack of assessment and planning to determine their individual wishes and aspirations. This left them at risk of being bored and unfulfilled.

Staff told us they had difficulty motivating some people to do activities and that it was mainly the same group of people that were involved in all the activities arranged within the home. There were some weekly activities such as music for health and aromatherapy. There was a monthly 'jaws for claws' activity where a variety of animals were brought to the home and people were supported to spend time with them. We were told that a number of day trips were organised throughout the summer months. Two people went out independently on a daily basis to places of their choice. Another two people used the local shops independently. Staff told us that if people wanted to go to the local shops they would take them. One person told us that people from their local church came to visit them weekly. Another person told us, "I go to a day centre and do knitting there." We asked if they ever did knitting at Barrington and they shook their head. They said they watched, "TV and sometimes do arts and crafts."

On the day of our inspection one person was knitting a blanket for the cat protection society. One person was supported with a jigsaw and another looked at clips of steam trains on the computer. Apart from this, people sat in the lounge with the TV on. At one point it was noted that they were looking at the screen but the volume was so low no one would have heard it. We asked if they would like the sound turned up and one person confirmed that they would. A staff member who had been sitting with another person immediately turned the volume up. This was a reaction to our intervention and we could not be confident that this would have happened if we had not suggested this.

There was a lack of full assessment and planning for meeting some people's social needs to ensure they were provided with opportunities for meaningful activities. We were told that one person had been taken out regularly to a destination of their choice. We asked to see the records related to these activities but whilst staff confirmed that the trips had taken place there were no daily records to confirm this or to state if the person had enjoyed their trips. Daily records provided limited evidence that people had been given choices about how they spent their day. They were repetitive and in some cases showed the main activity was watching the TV. Whilst some people may have preferred to watch the TV there was no evidence that they had been offered an alternative.

Support plans were stored electronically. Plans contained information and guidance about how to support people. The records contained detailed information about people's routines and the support they required to meet their individual needs. However, in some areas the information was less clear. For example, one person had a specific condition and whilst this was referred to within their overall care plan there was no information in their care plan to provide staff with guidance on how the condition affected them and how they should be supported. We asked a staff member how this condition affected the person but they did not

have a full understanding. Another staff member had some information about the condition but felt that the normal traits of the condition did not apply to the person. By the second day of the inspection the registered manager had printed information about the condition and was in the process of adding a care plan to provide advice and guidance for staff.

The above areas are a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The complaints procedure provided information about the process for responding to and investigating complaints. We were told there had been no formal complaints received. People told us that they knew who to talk to if they had any concerns or worried. Staff told us that they would feel comfortable raising concerns if they had any.

Requires Improvement

Is the service well-led?

Our findings

The culture at the home was open, relaxed and inclusive. People seemed very content and there was a warm atmosphere. A staff member told us, "There is strong management. They try to create a homely atmosphere." A relative told us, "They give a very good service." Despite this positive feedback there was a lack of monitoring to ensure that record keeping was up to date and accurately reflected the running of the home.

There was a registered manager in post who was assisted by a care manager and an assistant care manager. Roles and responsibilities for the management team had not been clearly defined and all management worked similar hours. Whilst some tasks were defined in terms of who had responsibility for addressing, other tasks were less defined and therefore no-one took responsibility for ensuring their accuracy. We discussed this with the registered manager who said they would review how they worked to divide up areas of responsibility and accountability. They also said that they would review the hours worked to ensure that there was a more even spread of management over the seven day period.

There was no system to monitor staff rotas and to ensure that the records accurately reflected the staff numbers on duty and their allocated duties. The rotas showed that between the hours 6-8pm, over a three week period, there were many instances where there were mistakes and one day showed no staff. However, all staff confirmed that there was always three staff on duty during this time period. One person was funded to receive one to one staff support for three hours, four times a week. The rotas did not show how these hours were allocated. We looked at the daily records for this person and although staff told us that they had gone out on particular days, this had not been recorded. There was no effective system to ensure that the person received their one to one hours and no advice about how this should be provided and appropriately recorded.

The home used an electronic system for care planning which guided staff to introduce set care plans for people. If the person person's needs did not fit in with the system it was difficult to accurately reflect their needs. For example, there were systems to monitor people's weight and to take appropriate action if a person's weight was below a safe level. However, three people could not stand on the weighing scales. We were told that there were procedures to measure various parts of the body such as arm, stomach and leg. There were no records for one person. Although there were records for two people there was no system to analyse what the readings meant. At least two of the people needed support to maintain low fat diets. However, because staff were unable to enter a weight on the electronic system, the system showed that they were low risk in terms of weight management. As a result there was no plan to ensure they were supported with their weight and to give staff guidance on how this should be achieved. There was no effective auditing of the care plans to identify these shortfalls and to take action to address them.

There were systems to check water temperatures to ensure that water provided to people was within recommended safety guidelines. Records showed that water in baths and showers had been tested but records for the majority of wash basins showed that water had been run for a minute but there was no record of the actual water temperature. This could have left people at risk of scalding.

Although staff received training in the management of medicines there was no system to assess their competency before being allowed to give medicines to ensure they followed correct procedures. The registered manager told us that they did not realise they needed to have such a system in place and whilst they always assessed new staff before determining they were competent, this had not been recorded. There was a tool for carrying out such an assessment but the registered manager understood that this only needed to be done if an error had occurred. They assured us that they would introduce a system to assess each staff member.

Although there was an expectation that all staff completed training appropriate to their individual roles within the home the systems to monitor that this had happened were not effective and records had not been kept up to date. Records for staff supervision were also inaccurate which meant that it was not possible to accurately determine if staff had received regular supervision and appraisal of performance.

There was an accident record for one person in January 2017 that showed that they had an unwitnessed fall. Staff had taken appropriate actions to deal with the accident. However in line with the home's policy, records showed that a full falls assessment should have been carried out. The format for the risk assessment was in the folder but this had not been completed. This meant that no assessment had been carried to try to learn from the incident and minimise the risk of a reoccurrence. This had the potential to place the person at risk of harm.

There were systems to seek the views of people, staff on a six monthly basis and from visitors on an annual basis but these were not effective. Results of the most recent surveys had not been analysed. We were told that the results of the surveys would have been fed back in staff and residents' meetings but we could not see this in the records available. As a result the systems did not show that the views obtained had been heard and there were no records of actions taken as a result.

Staff meetings were held monthly. In January 2017 it was shown that record keeping in daily notes had been highlighted as an issue and that people's personal care had not been attended to. In February 2017, the issue of personal care had been addressed and cleaning was assessed as good. Reference was made again to the need to improve daily records. There was also reference to increasing the amount of fruit and veg/salad for people. It also stated that senior staff would monitor these issues. However, if appropriate systems had been put in place to address these matters fully they would not have been identified again on our inspection. Although staff told us that they were able to share their views at staff meetings, minutes of the meetings read like a list of instructions and there was very limited evidence that staff had been involved in any discussion.

We were told that residents' meetings were held regularly. There were monthly records up until June 2016 and then no records until February 2017. Records of the February meeting showed that 11 people attended. People gave lots of suggestions of things that they would like to do. Whilst we were told that the majority had been addressed there was no written record that they had been done. One suggestion had been to have bingo as an activity and we were told that this was now a regular activity on Monday afternoons. People had requested a fish tank. We were told that the provider had not been in favour of this. However, staff were not sure if people had been advised of the outcome of this request. It was therefore not always evident that people's voice had been heard.

The electronic system for support planning was not operating effectively and there was no auditing system to check that care plans were accurate and included the key information needed to meet people's needs effectively. There was a lack of monitoring in place to ensure that staff had up to date training in all areas essential to their role. In addition there was no monitoring system to ensure that staff received regular

supervision and support for their role.

Although there were systems to carry out regular health and safety checks to ensure people's safety was maintained, these were not effective in practice and did not show that matters highlighted had been attended to promptly. A section of coving on the ceiling over one person's bed was missing. We were told some had come down and the rest of the missing section had been removed and sent away for repair. We were assured that the remaining coving had been checked and was safe and not a danger to anyone. There were no records to demonstrate this. There were a number of cracks on the wall both inside and outside of this room. We were told that the cracks were superficial and would be addressed as the room was to be redecorated imminently.

Within the shower room the shower chair in use was a plastic garden chair. We asked if the chair had been assessed as appropriate for use in a shower. No assessment had been made but by the second day of our inspection this had been replaced by a shower chair. The extractor fan in one of the small bathrooms was clogged with dirt. In one person's bedroom there were razors that were old and not useable. When this was pointed out to staff, the razors were removed. There was what appeared to be mould around the windows and wall on one side of the lounge area. We were told that this had occurred when there had been a problem with the roof, but that the roof had been repaired since. By the second day of our inspection the mould had been removed and the wall treated and this was to be painted with specialist paint. The systems in place to regularly monitor the building to ensure people's health and safety matters were not effective in that the matters listed above had not been identified and addressed promptly.

The above areas are a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager had systems to regularly audit the management of medicines. Where shortfalls were identified they had been addressed. A full infection control audit had been carried out in June 2016 and we were told that this was an annual audit.

The registered manager was aware of their responsibility to send notifications to CQC where appropriate. A notification is information about important events which the provider is required to tell us about. They completed a PIR (provider information return) in advance of the inspection. This included areas where the home was planning to make improvements. These areas included expanding the numbers of audits and reviewing the activities on offer in the home. Timescales for these improvements had been set for later in the year.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 There was no proper system in place to assess and plan to meet people's social needs. Regulation 9(1)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to give appropriate consideration to DoLS in accordance with legal requirements. 11(1)

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 not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks. 12(2)(a)(b)(d)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider failed to ensure that accurate record keeping was in place and to ensure actions were taken to mitigate risks.

17(2)(a)(b)(c)(e)