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SONACare

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 25 and 30 May 2017.

Sonacare is a detached property situated in a residential area close to the centre of Cleveleys. The home is registered to care for up to fifteen people assessed as requiring residential care. Accommodation is located on the ground and first floor of the building which can be accessed by a passenger lift. There is a communal dining room as well as a lounge area. The majority of bedroom accommodation is for single occupancy although there are two shared bedrooms for people who would prefer this option. On the morning of the first inspection visit 11 people resided at the home. An additional person moved in later that day.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected 07 April 2015. At this inspection we found the service was meeting all the fundamental standards and was rated as, 'Good.'

At this inspection visit carried out in March 2017, we found not all requirements had been met and the registered provider was not meeting all the fundamental standards.

Deployment of staffing did not always meet the needs of the people who lived at the home. Two people we spoke with told us staffing levels did not always meet needs. This meant they sometimes had to wait for assistance. We saw evidence of this occurring at the inspection visit. We found deployment of staffing was inconsistent which meant oversight in communal areas was not always achieved. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Staffing).

We looked at how the service managed risk to keep people safe. We found risk was not consistently addressed and managed. When risk assessments were present they were not consistently followed. We also found when risks were evident; these were not always addressed proactively. This was a breach of Regulation 12 of the Health and Social Care Act (2008) Regulated Activities, 2014 (Safe care and treatment).

Person centred care was not always considered and provided. One person asked for something to eat but this was denied. Three people had asked the provider to support them with their cultural needs. We found no evidence these requests had been addressed and actioned. This was a breach of Regulation 9 of the Health and Social Care Act (2008) Regulated Activities, 2014 (Person Centred Care).

Infection control and standards of hygiene within the home were poor. Communal chairs and carpets were stained. There was no evidence deep cleaning had taken place at the home. Hand washing facilities were not always adequate. This was a breach of Regulation 12 of the Health and Social Care Act (2008) Regulated

Activities, 2014 (Safe care and treatment).

We looked at how medicines were managed at the home. We found good practice guidelines were not always followed. Documentation of medicines management was poor. This was a breach of Regulation 12 of the Health and Social Care Act (2008) Regulated Activities, 2014 (Safe care and treatment).

People were not always protected from the risk of abuse. Staff responsible for providing care and support had knowledge of safeguarding procedures and were aware of their responsibilities for reporting any concerns. However, through the inspection process we identified an incident which had not been reported to the local authority safeguarding team and the Care Quality Commission (CQC) for review. Following the inspection visit we raised a safeguarding alert with the local authority safeguarding team. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment).

Processes were not consistently followed to ensure people were deprived of their liberty lawfully. We observed several restrictions were in place at the home which had not been considered as such. On the first day of the inspection visit not all DoLS applications had been submitted as required by law to ensure people were lawfully deprived of their liberty. This was a breach of Regulation 13 of the Health and Social Care Act (2008) Regulated Activities (2014) as suitable processes were not implemented to ensure people were lawfully deprived of their liberty.

We found the environment was poorly maintained and did not always meet the needs of the people who lived at the home. This was a breach of Regulation 15 of the Health and Social Care Act (2008) Regulated Activities, 2014 (Safe care and treatment).

We found privacy and dignity was not always considered and implemented by staff. During the inspection process we observed some interactions where dignity was not upheld. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014, (Dignity and respect.)

We looked at records maintained by the service. Records were not always stored appropriately so information could be easily accessed. We found records were not always accurate and up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good Governance.)

During the inspection visit we reviewed the auditing systems established and operated by the registered provider. We noted some audits did not take place. Those auditing systems in place were ineffective and failed to identify the concerns we identified during the inspection process. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good Governance.)

During the inspection visit we were made aware of an incident whereby police had been called to the home to provide assistance. This was a notifiable incident which should have been reported to CQC. This had not been completed. This was a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009 (Notification of other incidents).

We found the registered provider had failed to display their current rating as required within the Health and Social Care Act 2008 regulations. This was breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Recruitment procedures were implemented prior to people commencing work; however we found these

checks did not always ensure risks were fully assessed and decisions documented to ensure the suitability of staff employed. We have made a recommendation about this.

We received mixed feedback about the provision of recreational activities at the home. On the days of the inspection visits we observed some activities taking place at the home. These were not always appropriate activities and did not meet the needs of the people at the home who were living with dementia. We have made a recommendation about this.

The registered provider did not always consider the Mental Capacity Act 2005 (MCA) and the relevance to their work. We looked at processes in place for determining capacity and decision making. We found correct processes were not consistently followed. When people lacked capacity to make decisions for themselves, there were no capacity assessments in place to show capacity had been assessed. When decisions had been made on behalf of people there was no documentary evidence to show that decisions had been made in the best interests of people. We have made a recommendation about this.

We received mixed feedback about the quality of the food provided at the home. We discussed this with the registered provider who said they would look into this. Systems were in place for managing people's dietary needs. We saw evidence of input from health specialists when people were at risk of malnutrition.

We received mixed feedback about the caring nature of staff. Three people told us staff were not always caring. We observed some interactions which demonstrated that caring relationships were not always nurtured.

Staff said they felt supported within their role. They told us training was provided to meet their training needs.

We noted no complaints had been raised to the registered provider. We spoke with people who lived at the home about their right to complain. We received mixed feedback from people about being confident to complain and their complaints being taken seriously.

Systems were in place to seek feedback from people who lived at the home as a means to develop and improve service delivery. People were encouraged to have an annual review of their care to discuss their care. We saw however from the three reviews held, families and representatives were not routinely involved.

The registered provider had a system for managing complaints. People were aware of their right to complain. However, we received mixed feedback from people as to how complaints were dealt with. Two people said they could approach the registered manager if they had complaints. One person told us there had been occasions when they had raised concerns and they were disappointed in the staff response.

Staff at the home told us they considered the home to be well managed. They praised the approachability of the registered manager and the owner. Staff said the senior management team could be called upon for emergencies and would offer support when required. They described a positive working environment. Staff told us they received regular supervisions to assist them in their role. We saw recorded evidence this occurred.

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

this timeframe.

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

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

You can see what action we have asked the provider to take at the back of the main body of the 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?

Inadequate

The service was not always safe.

People who lived at the home and relatives told us people were safe we found evidence to show otherwise.

Staff were aware of their responsibilities in responding to abuse. However procedures were not followed to ensure safeguarding concerns were reported to external bodies.

Appropriate numbers of suitably qualified staff were not deployed to meet the needs of people who lived at the home.

Risk was not addressed and managed consistently within the home.

Recruitment procedures to assess the suitability of staff were not always effective.

Arrangements were in place for management of all medicines; however these were not consistently applied.

Is the service effective?

Requires Improvement

The service was sometimes effective.

People's health needs were monitored but advice was not always sought from other health professionals in a timely manner.

We received mixed feedback about the food provided at the home. Nutritional and health needs were met by the service.

Staff had access to ongoing training to meet the individual needs of people they supported.

Staff had knowledge of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) but this was not consistently applied to working practices.

Is the service caring?

Inadequate

The service was not caring.

We received mixed feedback about the qualities of staff who worked at SONAcare.

There was an emphasis on task focussed care. Personalised care was not always delivered. This impacted upon people's experiences of living at the home. Staff were rushed and did not always have time to care.

Dignity was not consistently promoted throughout the service. We saw people were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was sometimes responsive.

People's care records were kept under review and staff sometimes responded when people's needs changed.

Care plans focussed upon task orientated care and did not always incorporate peoples preferred needs and wishes.

The service had a complaints system that ensured all complaints were addressed and investigated in a timely manner. However not all people felt complaints were managed appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Paperwork and records were inaccurate, disorganised and difficult to locate.

There was poor oversight of the service. Procedures for responding to safeguarding concerns were ineffective. Processes for reporting statutory notifications were inconsistently followed.

An auditing system was in place but this was not fully operational or effective and did not appropriately manage risk. Risk was managed reactively rather than proactively.

SONACare

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 over two days on the 25 and 30 May 2017. The first day of the inspection visit was unannounced.

The inspection was carried out by one adult social care inspector. An inspection manager visited the home at the end of the first day to review findings and provide a briefing to the registered provider and the registered manager.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. We spoke with the Local Authority contracts and safeguarding teams as well as the Clinical Commissioning Groups responsible for commissioning care. We did this to check if they had any concerns. We were made aware the local authority safeguarding team was in the process of investigating safeguarding concerns raised about the service.

We reviewed information held upon our database in regards to the service. This included notifications submitted by the registered provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people.

We spoke with ten people who lived at the home to seek their opinion of the service. Because some of the people were living with dementia we received limited feedback. Therefore we carried out a SOFI (short observational framework for inspection.) This allowed us to try and understand what people were experiencing through observations. In addition, we spoke with two relatives to obtain their views about service provision.

Information was gathered from a variety of sources throughout the inspection process. We spoke with five members of staff. This included the registered provider, the registered manager, and three staff responsible

for providing care.

To gather information, we looked at a variety of records. This included care plan files relating to six people who lived at the home. We also looked at medicine administration records relating to people who received support from staff to administer their medicines.

We viewed recruitment files belonging to three staff members and other documentation which was relevant to the management of the service. This included health and safety certification, training records, team meeting minutes, accidents and incidents records and findings from monthly audits.

We looked around the home in both communal and private areas to assess the environment to ensure it met the needs of people who lived there.

Inadequate

Is the service safe?

Our findings

When asked, two people who lived at the home told us they felt safe. Responses included, "I feel safe." And, "I feel relatively safe."

Although people told us they were safe, we found this was not always the case. We looked at how the service addressed and managed risk. Although risk assessments were in place, we found these sometimes held conflicting information. For example, one person's care records contained two different falls risk assessments. One stated the person was at low risk of falls, another defined the person as a high falls risk. This meant instructions for managing the risk were unclear.

We found risk assessments were not routinely adhered to. For example, we reviewed a health and safety fire risk assessment which stated all fire doors were to be kept closed to prevent the spread of fire. During our inspection visits we saw three fire doors were wedged open with wooden door stops.

We looked at care records for one person in relation to eating and drinking. A nutritional information sheet stated the person had been assessed by the speech and language team and stated staff were to observe the person for choking. On the first day of the inspection we observed the person on their own in the lounge eating a meal. The person was unsupervised with no means of calling for help should they need assistance.

We looked at records relating to a person who was recently admitted to the home. We found all risks had not been clearly addressed and processes put in place to address the risk. This placed the person and visitors at risk of harm.

We reviewed care records relating to one person who was assessed as at risk of falls. We noted from accident records the person had slipped twice on the floor in the bedroom. There was no evidence to suggest their care plan and risk assessment had been reviewed to take these falls and the flooring type into consideration. We visited the person in their bedroom, we saw the person's walking aid and emergency alarm was inaccessible to the person. This increased the risk of the person falling and not being able to call for help if required.

One person had bed rails upon their bed. We asked the registered provider if there was a risk assessment in place for checking these as recommended within the Medicines and Healthcare Products Regulatory Agency, (MHRA) safe use of bed rails document 2013. The registered provider confirmed no risk assessments were in place. Bed rail risk assessments are recommended to ensure the risk of entrapment is considered and action taken to mitigate any risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safe care and treatment) as the registered provider had failed to ensure risks were appropriately addressed to mitigate and manage risk.

We looked at the arrangements for the management of medicines. One person told us they received their

medicines as directed. We watched a senior carer giving people their medicines. They followed safe practices and treated people respectfully. Medicines kept at the home were stored safely. Staff told us they could not administer medicines without being trained. All staff trained to administer medicines undertook regular competency tests. Staff told us only one staff member per shift was allocated the task of administering medicines. This was to promote consistency and prevent any medicines errors from occurring.

Checks had taken place on the storage, disposal and receipt of medicines; however these were not always accurate. For example, we found the stock count of one controlled drug had conflicting information on the medicines administration record to the controlled drug record. This had not been identified by staff for five days and the senior management team were not aware of this until we pointed it out. Controlled drugs are subject to tighter controls to prevent the risk of misuse.

Record keeping in relation to topical creams and ointments were poor and did not follow good practice guidelines. For example, creams and ointments sheets were used in place of the MAR sheet. Instructions on the sheet failed to indicate which areas of the body the cream was to be applied to.

One person had a pain relief patch prescribed. We looked at 21 entries made by staff on the MAR sheet. We noted on 20 occasions, staff had signed to show the patch had been administered but they had not completed the body map to show the position of the patch. This was necessary because the application site needed to be rotated to prevent side effects from the medicines. We highlighted this to the registered manager, they were not aware that staff had not been completing these records appropriately.

We spoke with a staff member responsible for administering medicines. They told us they were aware of the need to reposition the patch on a different area of the body and said they documented this on the body map. We saw no evidence this had occurred.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure medicines were suitably managed.

We looked at how safeguarding procedures were implemented and managed by the service. We did this to ensure people were protected from any harm. During the inspection we asked people about the staff at the home. Two people who lived at the home told us staff sometimes acted inappropriately. We made a safeguarding referral to the Local Authority safeguarding team following receipt of this information.

Staff told us they had received safeguarding training and were confident they could identify and report abuse. Although staff told us they were confident in identifying and reporting abuse we found processes had not been consistently followed to ensure people were not exposed to harm and abuse. During the inspection visit we saw that one person had severe bruising to their body. The person was unable to tell us how the bruising had occurred. We spoke with the registered manager about the bruising. They told us the person had a history of bruising easily and may have occurred when the person was assisted to mobilise. This was not however documented within the person's care plan or risk assessment. In addition staff had not investigated how the bruising had occurred. There was no evidence within the file to show that all unexplained bruising was explored and reported to the relevant agencies including the CQC and the Local Authority safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment) as systems were not implemented and followed to ensure people were protected from abuse and harm.

We spoke with three people who lived at the home and relatives about staffing levels. We received mixed feedback about this. One person said, "I am not rushed at any time." Two people said they did not think staffing levels consistently met their needs. Feedback included, "There are not enough staff on duty. There is one member of staff off for two weeks so they are one down." And, "They could do with three carers at certain times." Also, "Sometimes the staff say they won't be a minute and they are gone ages. We have to wait."

We spoke with a relative and asked them their opinion on staffing levels. They told us, "At times I think it's understaffed. At times I think a third person may well need to be on shift. There is an increased strain on staff at busy times. Staff are generally under strain."

We looked at the rota for staffing. Two staff were on duty during the day. This decreased to one staff during the night with an additional staff on sleep over duties in case of emergency. In addition to caring tasks we were informed staff also had a responsibility for completing cleaning, laundry and cooking tasks when the cook was not on duty.

We asked staff their opinion on staffing levels. They said current staffing levels sometimes allowed them to carry out their tasks. One staff member said, "Staff do the extra jobs in the afternoon. Occasionally we get a bad day when we are pushed to complete all jobs. We do as much as possible." And, "At certain times we could do with an extra pair of hands." Another member of staff told us there was presently no cleaner on at weekends so staff had to carry out additional cleaning duties at weekends also.

We spoke with the registered manager and provider about staffing levels. They told us they supported staff at the home, providing hands on care when required. They said on this occasion they had been unable to provide support and assistance to staff as they were busy completing paperwork.

We found deployment of staffing was not always consistent to meet people's needs. On the first day of inspection we observed one person deemed at risk of choking left unsupervised in a communal area eating their lunch. The persons care plan stipulated the person required monitoring whilst eating. No staff were present whilst the person ate their meal. This lack of oversight meant the person had no means of summoning help from staff should they start choking or need any assistance.

We observed another person who was at risk of falls sitting in a communal area. The person required assistance with mobilising. On two occasions we observed the person walking about unassisted, without their walking aid. On one occasion we observed the person picking up a piece of furniture and moving it. No staff were deployed within this area to ensure oversight of the person. We discussed this with the registered manager, they told us the person was not well and this had resulted in an increase in the person's confusions and behaviours. Despite being aware of this, deployment of staffing had not been reviewed to mitigate any risk towards the person.

One person was supported to return to the lounge after their lunch. The person was seated in a chair and left unsupervised. We observed the person calling out twice for help to wash their hands. No staff were present to help with this request and this person spent the rest of the afternoon in their chair with their hands unwashed.

On the first day of the inspection visit we observed a member of staff playing a board game with people. One of the people who lived at the home passed comment about the activity and said to the staff member, "Its ages since we have played this. We don't usually have time for this do we?"

We observed people being told they would have to wait for assistance. On the first day of the inspection visit one person asked to go to the bathroom. The person required two members of staff to help them with mobilising. A staff member heard the person requesting help and went to find a second member of staff. It took ten minutes for two staff to respond to the person's request for help. We discussed this with the registered manager and the registered provider. The registered provider said keeping the person waiting for ten minutes was not acceptable.

We spoke with the registered provider and registered manager about staffing levels. They told us they would usually offer support to people who lived at the home if there was a need. They said they had been unable to do so on this occasion as they had paperwork to complete. Following our inspection visit the registered provider said they were going to review deployment of staffing at the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Staffing) as the registered provider had failed to ensure staff were effectively deployed at all times.

We undertook a visual inspection of the home and found the living environment was not always suitable for purpose and was not always suitably maintained. On the first day of inspection we noted disused items were stored underneath a fire exit. This posed as a fire hazard as some of the goods were combustible and if set alight could block the fire exit. At the front of the home the driveway had moss growing upon it. This presented as a slips trips and falls hazard. A hazardous waste bin was stored at the front of the home. This was unsecured, which meant the public could access this. Underneath the waste bin we saw there was a used continence pad decomposing.

During the walk around we found one communal bathroom was in a poor state of repair. We saw that a disused showerhead was covered in lime scale. The bath panel was broken leaving exposed sharp edges and there was a crack in the sink and toilet cistern. We tried taps in four people's bedrooms and noted every tap we checked was faulty. Water leaked from the tap fitting as opposed to running into the sink.

Decoration within the home was in a poor state of repair. We observed one crack in a wall which had been cellotaped over. One bedroom had wallpaper peeling off the wall and there was a crack in the ceiling. One piece of wallpaper was missing in a communal area. There were chips in walls and doors in the main entrance way, exposing plaster and wood. The carpet in the front lounge was frayed and there was unused equipment including a weighing scale chair stored in the front room. The unused equipment posed a risk hazard as people could trip, slip and fall over the equipment. Blinds at the front room window were torn and the beaded cords were not secured.

We found door wedges were routinely used on two bedroom doors and a communal lounge door. We discussed the use of these with the registered provider. They told us they were used as people had expressed a preference to have their doors open. No consideration had been taken to amend the equipment to make them accessible to people whilst also maintaining safety.

We looked in the kitchen at the insectocutor in place to kill insects and flies and noted this had not been emptied. The registered provider told us this should be emptied weekly. There were a large number of dead flies and insects which indicated the procedure had not been followed. This meant pest control was not being monitored which was a risk as there was no fly screen to the window or door; both of which were open.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure that premises were suitably maintained and fit for purpose.

We pointed out concerns about the environment to the registered provider and the registered manager. They agreed to take immediate action. On the second day of the inspection visit we saw some improvements had been made. The rubbish underneath the fire escape had been removed and works had started upon repairing taps. Following the completion of the inspection we received written confirmation the registered provider was planning to develop a refurbishment plan and had requested a quote to replace the upstairs communal bathroom. They also confirmed all taps had been replaced and were fully functional.

We reviewed levels of cleanliness and hygiene at the home. We found one communal bathroom was dirty. We observed black staining around the bath seal and a toilet raiser seat had faeces on it. We found communal towels for people to use for bathing in both bathrooms. This posed a risk as people can be exposed to cross infection from using communal items.

We found the laundry area was in a poor state of repair with exposed plaster. These meant areas could not be effectively cleaned. Areas of the carpet in the lounge and some communal chairs in the lounge had stains upon them. We viewed three mattresses, all of which were stained. There was a brown stain on the communal lounge door.

On the second day of our inspection visit the registered provider told us some action had been taken to improve standards of hygiene. They told us carpets had been deep cleaned and chairs had been disinfected. We saw evidence that an industrial carpet cleaner had been hired. However, we found that stains on the carpet and chairs which were present on the first day still remained, as did the brown stain on the communal door.

We asked the registered provider who was responsible for ensuring infection control processes were maintained. The registered provider told us one member of cleaning staff was employed for two hours per day, five days per week to undertake cleaning tasks. Care staff were expected to carry out additional tasks. We asked to see cleaning schedules to show that cleaning had taken place. We were not provided with any information to show cleaning schedules were maintained.

This was a breach of regulation 12 of the Health & Social Care Act 2008, (Regulated Activities) 2014 as the registered provider had failed to ensure infection control processes were implemented and actioned.

Following our inspection visit we made a referral to the infection control prevention team.

We reviewed accidents and incidents at the home. Accidents and incidents were recorded on accident forms and action was taken as required.

We looked at recruitment procedures to ensure people were supported by suitably qualified and experienced staff. To do this we reviewed three staff files. Employment checks were carried out prior to staff starting work. The service kept records for each person employed. Two references were sought and stored on file prior to an individual commencing work. One of which was the last employer. When gaps in employment history were present on application forms, these had been discussed and had been explored with each applicant.

The service requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a statutory requirement for people providing a personal care service supporting vulnerable people. The service checked this documentation prior to confirming a person's employment. Staff told us they could not start work without a valid DBS certificate. When a

disclosure had been recorded on one staff members DBS we saw evidence further information had been gained from the registered provider to establish facts of the incident. Although the provider had established facts we found that risks were not routinely assessed and actions documented within the staff file of actions taken.

We recommend the service reviews recruitment processes to ensure the suitability of staff is reviewed and risk assessed prior to staff commencing work.

We also looked at documentation relating to the health and safety of the home. All required certification was up to date.

Requires Improvement

Is the service effective?

Our findings

We asked people who lived at the home if they had access to health care services to meet their health needs. Feedback included, "My GP is in [Town], where I live, they take me there if I need to go." And, "I see the GP about my legs and knees and toes I have ointment to put on them."

We looked at individual care records to look for evidence of partnership working with health professionals. We saw evidence of people attending appointments at the hospital and opticians.

Although we saw records of some health professional involvement, we found health professionals were not always consulted with in a timely manner. We reviewed daily records relating to one person who lived at the home. Staff had recorded the person complained of being ill and requested to see their doctor. The person asked on two occasions to see a doctor and complained of being ill. It was nine days from the first complaint being raised until the doctor was called to review the person's health needs. When the doctor visited the person was diagnosed with an infection. This inaction from staff placed the person at risk of harm as risks had not been assessed and interventions had not been sought from a health professional in a timely manner.

We spoke with the registered manager about this. They told us the person was not known to complain of the specific condition. The registered manager could not provide any explanation as to why there was a delay in requesting guidance from the doctor. They told us they had not been aware of this concern until we identified it.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure appropriate advice and guidance was sought in a timely manner.

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.

We looked at care records and found evidence that people were asked to consent to their care. For example, people had been offered the opportunity to consent to care and treatment and to having their photographs taken.

We asked a relative if their family member was able to make decisions. They confirmed their relative had capacity and was involved in making decisions about their care.

We asked the registered manager about processes in place for supporting people who lacked capacity to make decisions. They confirmed nine people who lived at the home had fluctuating capacity and at times may need support to make decisions. Good practice guidelines were not consistently followed. For example,

we saw no evidence of any mental capacity assessments in people's records, nor was there any documented evidence of best interests meetings taking place. We discussed this with the registered manager they told us discussions took place with relevant people when required but these were not documented. The registered provider then took immediate action to design a best interest's template so decisions could be documented.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2008 as the registered manager had failed to ensure processes had been followed to lawfully deprive people of their liberty.

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). During the inspection visit we saw that several restrictions were in place throughout the home. For example, all external doors were locked at all times, a key-code lock was in place in the kitchen and stair gates were in place to restrict movement on stairs.

We spoke with the registered manager about this. The registered manager told us nine people lacked capacity. They told us DoLS applications were in place for some of the people who lived at the home and provided us with four completed applications. Of these applications, only one person still lived at the home. The registered manager told us other applications had been submitted but they were not sure who for and how many had been submitted. At the end of the first day we were told three applications had been submitted. This meant six people who lived at the home who lacked capacity had not been assessed and restrictions on their liberty reviewed. At the end of the inspection visit we received written confirmation these had been reviewed and all applications had been submitted.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) as the registered provider had failed to ensure suitable systems were implemented and consistently applied to ensure people being deprived of their liberty were done so lawfully.

We looked at how the service met people's dietary needs. We spoke with six people who lived at the home about the food provided. We received mixed feedback about the quality of the food. Feedback included, "The food leaves a lot to be desired. The care staff often cook the food. We eat because we are hungry." And, "The food provided is pretty good. We get a good choice." And, "'The food is alright." Also, "The food could be worse and it could be better."

We spoke with the registered manager about the comments people had made to us. They said no one had complained about food before. They agreed to look into this and review the food provision at the home.

On the first day of inspection we observed meals being served. We did this to understand the experiences of people who lived at the home. We noted the dining area was cramped. One person told us there was not enough room in the dining area for their wheelchair. However they told us they were happy with the current arrangements of eating in the lounge.

At lunch time people were served corned beef hash with potatoes and carrots. We saw one person was provided with alternative food as they did not like the main meal. People also had a choice of two puddings. One person returned some food to the kitchen as they said they were full. In the afternoon we overheard staff speaking with people asking them what they would like for their evening meal. People were offered a variety of choices.

We looked at how the registered provider supported people at risk of malnutrition. We saw people's weights were monitored and people were referred to the appropriate agencies if they experienced significant weight loss. Also, when there were concerns about people's weight dietary intake charts were completed.

We asked staff about how they provided support to meet the needs of people with a dietary related medical condition. Staff had a good knowledge of how to support the person and what action they needed to take in the event of an emergency.

We asked people who lived at the home if they thought staff had the appropriate training to allow them to deliver high quality and effective care. One person said, "Staff know their job. They have all the information to know if something isn't right."

Staff told us they were happy with the training opportunities made available by the registered manager. Feedback included, "I have had the basic training, but it covers the basics of what we need." And, "The training is okay here. I have done safeguarding training and I am going to do some training shortly around stoma care."

The registered manager maintained a training matrix to document the training needs of staff. We reviewed the information provided on the training matrix and noted there had been a significant amount of training provided to staff during this year. Training included moving and handling, safeguarding of vulnerable adults, food hygiene and dementia awareness.

We spoke with two members of staff employed at the home. One member of staff had recently been employed. They told us they undertook an induction period at the commencement of their employment. They said, "I had a week's induction. I shadowed staff on day shifts and also a night shift just in case."

We spoke with staff about supervision. Supervision is a one to one meeting between the staff member and a senior member of the staff team to discuss any concerns and training needs. Staff confirmed they received regular supervision with the registered manager. All the staff we spoke with said the senior managers were approachable and they were not afraid to discuss any concerns they may have in between supervisions.

Inadequate

Is the service caring?

Our findings

We asked relatives about the standard of care provided at the home. We received mixed feedback. Two people and one relative praised staff. Responses included, "Staff are very pleasant.' And, The staff are very good." Although we received some positive comments, four people and one relative said the quality of the care varied depending on which staff were on duty and how staff were feeling. People told us, "I like the majority of staff but one or two I could do without.' And, "The staff could be worse, could be better." This was confirmed by a relative who said, "The care is alright. The staff are variable."

We found dignity was not considered and promoted at all times. For example, we had to highlight the need for dignity locks to be fitted to communal bathrooms. Also, we observed one person sitting in their wheelchair. The person's skirt had ridden up and the person's thighs were exposed. The person was left with their legs on show as staff did not notice.

We observed a person being told they had to wait to use the toilet. The person had to tell the staff in public, that their incontinence pad was leaking before staff responded. We discussed this incident with the registered manager. They said this practice was unacceptable.

We spoke with a relative about dignity and care. They told us their relative sometimes had their dignity compromised when they were left sitting on a commode for a long time. They told us, "It is not unknown for my relative to be left for half an hour or so sat on the commode."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure people were treated with dignity and respect.

We found care was sometimes delivered around the needs of staff, not the people who lived at the home. One person said, "If I ask to use the bathroom at five o' clock in the morning, they just get me up and dressed." We asked the registered manager about this. They told us people should be allowed to stay in bed and get up when they wished. This contradicted to what this person told us.

During the inspection process we observed one person who was living with dementia repeatedly telling staff they were hungry. A member of staff told the person they could not have anything to eat and said they would have to wait for a drink and biscuit to be served later that afternoon. We raised this concern immediately with the registered provider. They said this was not the case and promised to go and bring some food for the person. The registered provider left the room and did not return with any food. The person did not receive anything to eat until tea and biscuits were served later as initially informed.

We looked at minutes of three individual service review meetings which had taken place this year. A service review meeting is a meeting held with people to gauge feedback on how well the service is doing and what improvements need to be made. Each person had expressed a wish to attend church. We asked the registered provider what action had been taken to meet the spiritual needs of these people. They confirmed no action had been taken and people had not been supported to church.

We noted from daily records that staff had removed a personal possession from a person when the person was making noise during the night. This infringed upon the person's rights as they had removed this as a negative control measure as they were unhappy with the person's behaviour. We spoke with the registered manager about this. They told us they were unaware of the incident and said it should never have happened. They said," That's just not good enough. They can't be doing that."

Two people who lived at the home said did not feel confident in calling for help from their bedrooms due to staff response. One person said, "Staff come straight away when I call them but they tell me not to keep pressing it so I try to be careful not to keep pressing it.' Another person said, "I won't call the bell unless it's urgent." This demonstrated that staff lacked compassion and empathy as people were not encouraged to seek assistance when needed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure care met people's needs and preferences.

People told us said staff did not always act in a professional manner. Feedback included, "[Staff member] gets worked up. I know they have problems of their own but they aren't here." And, "The care is good on the whole but it does vary if they have a bad day."

We spoke with a relative, to ask them their opinion of the care provided. They told us, "Staff tell [my relative] they are busy completing paperwork. They say, "I have all my reports to do, I can't come now."" This demonstrated at times, staff tasks were prioritised over the needs of the people who lived at the home.

During the inspection process we received some information of concern in regards to conduct of staff at the home. We raised a safeguarding alert to the local authority in response to this.

We saw some positive interactions between people who lived at the home and staff. For example, we saw one person smile when the registered provider entered the room. They placed their hands up in the air and cuddled the registered provider. We over heard a person telling another staff member they were 'alright.' The staff member laughed and joked with the person. The person looked comfortable in the staff member's presence. Although we saw some positive interactions these were minimal. Good interactions were often hindered as staff did not have time to sit and engage with people due to an emphasis upon the provision of task focussed care.

We looked to see how people who could not make decisions by themselves were supported to make choices. The registered manager told us one person at the home had an advocate who supported them. They told us family were also involved in making decisions where appropriate. One relative confirmed they were involved in supporting their family member to make decisions. They said, "We sit and discuss things."

We spoke with relatives about visiting arrangements. Both relative's we spoke with told us they were able to visit the home whenever they wished. We observed visitors at the home and noted they were able to access communal areas and family member's bedrooms. Visitors looked at ease at the home.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the home about the variety of activities on offer. We received conflicting information as to whether or not activities took place. Responses included, "We sometimes play darts, they do put on activities." And, "We have no activities." And, "They do put on activities, but they treat us like children with the games."

We looked at an activities planner on the wall. During the inspection visit we found the activities planner did not always reflect what was offered and provided. Staff told us they carried out activities with people in the afternoon. They said they supported people to do activities such as darts and dominoes.

We observed no activities taking place in the afternoons of our visits. On the first morning we saw one staff member encouraging people to play snakes and ladders. On the second morning we observed staff supporting people in the communal lounge to take part in a word search game. For some people who were living with dementia this was not appropriate and people could not engage. We saw no other evidence of activities taking place which were tailored to meet the needs of people living with dementia.

We recommend the registered provider reviews good practice guidelines as a means to ensure activities provided are person centred and according to people's needs.

We spoke with one person about their experience when they moved into the home. They told us they were involved in developing their plan of care. They said, "We had a long chat when I moved in. They had a checklist of questions they ask."

We looked at care records relating to four people who lived at the home. Care plans detailed people's own abilities as a means to promote independence. They addressed a number of topics including health promotion, skin integrity, personal care, mobility, nutrition and spiritual wellbeing. Although these care plans were in place we found they were not consistently followed. For example, one person's care plan said staff were to regularly offer the person the opportunity to visit the local church as a means to meet their spiritual needs. We saw no evidence of this within the person's daily records. The registered manager confirmed this had not been actioned.

We spoke with a relative about the care planning process to ensure care plans were updated and reviewed when peoples' needs changed. They told us they were consulted with but said, "We go through care plans and make suggestions to make changes but they never happen."

We looked at how people were listened to, to ensure their views were taken into consideration. On the days of the inspection visit no one had any complaints about the service. People told us they were offered the opportunity to raise concern. One person said, "If I have complaints I talk to [registered manager] and they resolve it."

The registered provider told us they held regular meetings for people to voice any complaints. We reviewed

resident meeting minutes. We saw people were offered the opportunity to voice their opinions about the service at these meetings. People confirmed they were offered the opportunity to complain.

We asked the registered manager about complaints. They said they had never received any complaints and as such had none documented. This conflicted with feedback we received. One person who lived at the home said, "I have complained about the food but nothing ever changes. We have residents' meetings but nothing ever changes. They'll say it does but it doesn't."

One relative we spoke with said they regularly made complaints to the service. They said, "Oh yes I have made complaints, mainly about the time element and [relative] having to wait." The relative told us the registered manager would act to resolve complaints. However they felt that other staff were less reliable and did not always take the required action to remedy any concerns.

One person told us in their experience staff sometimes responded negatively when they raised concerns. They said staff took comments personally and asked them why they had complained. We fed this back to the registered provider. They said they would look into this further.

We recommend the registered provider reviews and implements a complaints procedure in which people's voice is encouraged, heard and acted upon.

Inadequate

Is the service well-led?

Our findings

We asked people about the management who ran SONAcare. Two people who lived at the home described management as, "alright." Another person told us they weren't sure who the managers were. Both relatives we spoke with considered the home to be appropriately managed.

The service had recruited a new registered manager since the last inspection carried out in April 2015. We received positive feedback about them. Feedback from staff included, "They are a good manager. Approachable." And, "[Registered manager] is a good leader." One relative said they had faith in the registered manager stating they "were on the case" at ensuring things were appropriately managed.

Although we received positive feedback about the registered manager we found the home was not consistently well managed. One relative told us, "We have some concerns. They are only small things but when they are put together they can become big things. If the home could iron out some of these idiosyncrasies they would be much better." The relative said in their opinion the registered manager had too much to deal with, which contributed to some of the inefficiencies of the home. They said, "They [the registered manager] have a lot on their plate. Clerically things weren't up to date when they started. This impinges on the care."

During the inspection process we reviewed the quality and accuracy of the documentation maintained by the service. We found inconsistencies in the quality of the record keeping. For example, medicines administration records were not always completed appropriately. Care records held inaccurate and conflicting information. Risk assessments in place did not always reflect risk. Body maps for unexplained bruising and applications of creams and transdermal patches were missing. Discussions with people about their care and treatment and associated risk were not consistently documented to show that discussions had taken place.

Storage of records was poor. Records were not archived in such a way that information could be readily accessible. A file for all DoLS applications was not up to date and did not contain all the required information.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good governance) as the registered provider had failed to ensure records maintained were accurate and up to date.

During the inspection visit the registered provider described an incident whereby police had been called to the home. We asked the registered provider if they had followed procedure and submitted a statutory notification to the CQC to record this event. The registered provider assured us the notification had been submitted. We reviewed our records and found this was not the case. We spoke with the registered manager and they told us there had been an error. We requested this was resubmitted. We received this three months after the original incident had taken place.

This was a breach of Regulation 18 of the Care Quality Commission Registration Regulations as the registered provider failed to make all statutory notifications within a timely manner.

We spoke with the registered manager about audits. They showed us an auditing system which included the auditing of infection control, medicines and personnel files. Although there was an auditing system in place, this was ineffective as the audits had failed to identify the concerns we found during the inspection process. For example, the medicines audit made reference to good practice guidelines but these had not been routinely followed by staff. The infection control audit failed to notice all the concerns within the living environment including the poor cleaning standards throughout the home.

We saw that people were encouraged to give feedback through their annual service reviews. We saw no further evidence to show that relatives and health professionals were consulted. We spoke with the registered provider about this. They told us they consulted with relatives on a frequent basis and at annual reviews. This was not documented however.

This was a breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Good governance) as effective auditing systems were not consistently carried out to ensure care delivered was safe and effective.

As part of the inspection process we looked to ensure the registered provider was meeting their statutory requirements in displaying their CQC rating. We found the registered provider had their ratings certificate upon display in the home. They did not however, have this clearly on full display upon the website as stated within the guidance.

This was a breach of Regulation 20A of the Health and Social Care Act (2008) Regulated Activities 2014.

We found there was poor oversight of activity at the home. We spoke with the registered provider and the registered manager about three separate significant incidents of concern. They told us they were not aware of any of these documented incidents. They were therefore unable to give any explanation as to why incidents had occurred. Similarly it meant that action hadn't been taken in a timely manner to rectify these concerns.

One relative we spoke with told us that leadership was weak. They described a working environment where staff turnover was high. They said, "Staff turnover is incredible." They said the registered manager was committed to making improvements and would offer assurances. They said however, in their experience other staff did not always listen to instruction and take information on board. This led to a lack of consistency in care.

We found safeguarding concerns were not always dealt with in an open and transparent way. For example, a person had unexplained bruising but this had not been reported to the local authority safeguarding team or the CQC as required.

Outcomes for people who lived at the home were poor. People told us their concerns and wishes were not always taken seriously. Privacy and dignity was not a core concept of service delivery. Care provided was sometimes centred around the staff and their needs not the people who lived at the home.

We found the registered provider had failed to develop a staff team to ensure staff demonstrated the right values and behaviours at all times. For example, staff telling people they couldn't have anything to eat or telling people they had to wait to go to the bathroom.

Staff said they were happy with the way in which the service was managed and the responsiveness of the senior management team. One staff member said, "They will listen to you."

Staff told us they had regular team meetings on a regular basis. We were informed by staff they were able to contribute to meetings and offer suggestions as to how the service could be improved.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to notify the Commission without delay of all statutory incidents in a timely manner. 18 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered manager had failed to ensure care and treatment provided to people was appropriate, met their needs and reflected their preferences. 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered manager had failed ensure people were treated with dignity and respect. 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had failed to assess the risks to the health and safety of people and do

	all that was reasonably practicable to mitigate risks to ensure care and treatment was provided in a safe way. 12 (1) (2) (a) (b) The registered provider had failed to ensure suitable systems were in place for the proper and safe management of medicines 12 (g) The registered provider had failed to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; 12 (2) (h)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had failed to ensure systems and processes were established and operated effectively to prevent abuse of people who lived at the home 13 (1) (2) (3) The registered provider had failed to systems were in place to ensure people were lawfully deprived of their liberty. 13 (5)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure all premises used by people who lived at the home were clean and properly maintained 15 (1) (e)
Regulated activity	**Regulation**

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. 17 (2) (a) The registered manager had failed to assess, monitor and mitigate the risks relating to the health and safety and welfare of people who lived at the home. 17 (2) (b) The registered provider had failed to maintain an accurate, complete and contemporaneous record in respect to each person who lived at the home 17 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider had failed to ensure their performance rating was displayed conspicuously on their website.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure suitable numbers of staff were deployed to meet the needs of people who lived at the home. 18 (1)