Care One Limited

# Abbey Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This focused inspection took place on 27 June 2016 and was unannounced. Abbey Care Home provides accommodation and personal care and support for up to 11 older people, some who may be living with dementia. At the time of our inspection there were 9 people who lived in the service.

This inspection was to see if the provider had made the improvements required following an unannounced comprehensive inspection at this service on 13 January 2016. At the inspection in January we had found four breaches of legal requirements in relation to Regulation 12, 17, 18 and 20. We issued a warning notice for regulation 12 which was to be met by 30 May 2016. Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance. This inspection primarily was to follow up on the progress the provider had made in meeting the warning notice. The overall rating from the inspection in January was Requires Improvement. One domain of 'Safe' was rated as Inadequate at that time. At this inspection we found some, but not enough improvements had been made to meet the relevant requirements. We also found a continued breach in relation to regulation 18 with regard to sufficient staffing, and regulation 17 with regard to maintaining an accurate and complete record in respect of each service user, including a record of the care and support provided to the service user and decisions taken in relation to the care and support provided. An additional breach was also identified in relation to regulation10 which related to ensuring people were treated with dignity and respect.

This report only covers our findings in relation to the previous breaches and if the provider had met the warning notice. Any additional breaches found will be noted in this report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Abbey care Home' on our website at www.cqc.org.uk

The service had a registered manager in post who was also the provider. Since the last inspection the previous manager had left and returned as the deputy manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

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At this inspection we found the service had increased their staffing during the weekdays, but at weekends had still not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care when staffing was very low. There were insufficient members of staff available to meet people's care needs and staff were not appropriately supported in relation to their responsibilities,

to enable them to deliver care and treatment to people safely.

The service also did not assess and monitor the quality of service provision adequately this was with particular reference to areas relating to infection control and the environment. Risks to people were being managed but the service was not always proactive in assessing the risk. This raised concerns with us that people may experience unsafe care because insufficient actions had been taken to mitigate the risks to ensure their needs were being met safely.

People were protected from the unsafe administration of medicines. Staff responsible for administering medicines had received training and were subject to competency assessments to ensure people's medicines were administered, stored and disposed of correctly.

The service was now meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Appropriate mental capacity assessments and best interest decisions had been undertaken by relevant professionals and appropriate referrals had been made by the service. This ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice. The Act, Safeguards and Codes of Practice are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals.

Whilst in the main we noted that staff interacted with people in a caring, warm and friendly manner, we observed occasions where people were not referred to respectfully either verbally or in written documentation such as care plans. staff did not always respect people's dignity as they were not self aware around their actions and the terminology they used when referring to people.

Where people were not always able to express their needs verbally we saw that staff responded to people's non-verbal requests and had a good understanding of people's individual care and support needs.

Our inspection of January 2016 found that the planning and delivery of care did not always ensure the welfare and safety of people using the service, as care plans and records did not always reflect people's current needs. At this inspection we found that some improvements had been made, however not all the areas identified had been appropriately addressed. Care plans did not all contain suitable guidance to allow staff to care for people in a safe and effective way including ensuring they reflected current specialist care needs such as catheter care and different types of dementia, in line with people's changing needs.

Training had been delivered to staff, however not all staff had received sufficient training in dealing with people's behaviour which could place others at risk, supporting people's mental health needs or needs related to specialist healthcare needs such as dementia. This lack of training and guidance available to staff placed people at potential risk.

Whilst we note that some formal audits had been undertaken since the last inspection, we noted these were still not effectively monitoring the safety and suitability of the premises. Evidence we were shown did not highlight effectively that systems were in place to identify, assess and manage any risks related to the service. This with particular reference to systems in place to ensure an effective infection control programme was in place, which was risk assessed and monitored to mitigate the risk of cross infection. Audits, completed by the provider and registered manager and subsequent actions had not all resulted in improvements and the proactive development of the service.

Effective quality assurance systems were not fully in place to identify areas for improvement and

appropriate action to address any identified concerns.  Systems were not fully in place to gain the views of people, their relatives and health or social care professionals. The provider had quality assurance systems in place to identify areas for improvement, however appropriate action to address any identified concerns had not always been taken. Audits, when completed by the registered manager and senior staff and subsequent actions had only resulted in improvements in the service when highlighted at recent inspections. These were of a reactive nature rather than proactively being noted by the service as an on going process through their own monitoring systems.

You can see what action we told the provider to take at the back of the full version of the report summary.

We have also made an additional recommendation in this report with regard to dignity and respect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

There were insufficient numbers of staff available at all times, especially weekends to meet people's needs and to keep people safe.

Risks to people's safety were not always well managed. The service was not always proactive in assessing the risk.

Infection control practices at the service were not consistently safe.

There were systems in place to ensure people received their medicines safely and by staff who were trained to do so.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

The provider did not fully ensure that people's needs were met by staff with
the right skills and knowledge. Staff had not all got up to date training.

People had their nutritional needs met.

Staff had knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and how this Act applied to people in the service.

The environment at the service was not monitored sufficiently to be safe for people at all times.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Staff had a caring and supportive approach to the care they provided for people. we observed caring interactions between staff and people who used the service.

People were cared for by staff who knew them well.

Staff did not always respect people's dignity as they were not self aware around their actions and the terminology they used when referring to people.

Staff supported them to be involved in making decisions about their care.

## Is the service responsive?

**Requires Improvement**

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

People's care was personalised. However their care plans did not reflect their wishes and preferences or people's skills in relation to their personal care in order to promote their independence.

People were supported to make choices as they were able about how they spend their time and pursued their interests.

Appropriate systems were in place to manage complaints.

# Abbey Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 27th June 2016 and was unannounced.

The inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and asked them about their experiences of the service provided to people. We also looked at the action plan supplied by the provider.

We focused on speaking with people who lived at the service, speaking with staff and observing how people were cared for. Some people had complex needs and were not able, or chose not to talk to us. We used observation as our main tool to gather evidence of people's experiences of the service. We spent time observing care and support in the lounge including during the lunch time meal

We spoke with three people who lived in the service, two care staff members, one visiting relative, the deputy manager and the manager and a visiting healthcare professional.

We looked at four people's care records, staffing rotas and records which related to how the service monitored staffing levels. We also looked at information which related to the management of risk within the service such as infection control records, quality monitoring audits and checks on the environment.

Inadequate

# Is the service safe?

## Our findings

At our inspection in January 2016 we found the service had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care. Staff were not appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people safely. The service also did not assess and monitor the quality of service provision adequately this was with particular reference to areas relating to infection control and the environment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had also found there were not sufficient, experienced staff deployed to keep people safe or assist them to receive appropriate care and support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by the end of May 2016. Whilst we found that some Improvements had been made, the provider was still not meeting all of the requirements of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found at this focused inspection there was a continued failure to ensure there were sufficient numbers of staff available to support people with their needs at all times. On the day of our inspection we noted that two care staff had been allocated for nine people alongside the deputy manager who told us they provided hands on care support to people. A cleaner was also on duty. This meant that one carer supported people with personal care and then at approximately 10.00 am took on the role of the cook, preparing and cooking the midday meal. This meant that the staff member left supporting the other people at the service at the time, would not be able to respond effectively to people's needs if they required more than one staff member's support. When we arrived the breakfast meal was being served and we noted one carer feeding two people at once. Additionally we noted that another staff member (who we were told was employed as a carer) came in to do activities but this was not as part of a structured plan, but was done on an ad hoc basis. The staff member told us they enjoyed doing this when they could in their spare time.

Staff told us that staffing levels had improved since the last inspection with one additional carer provided during the week days now. Whilst we acknowledge that there was no one who currently required two staff for support to mobilise safely, the majority of people had been diagnosed with dementia or a mental health condition. We noted that there were people who required constant monitoring to protect them and others from the risk of harm. For example during our lunchtime observations we noted that two people were left on their own in the dining room. One person was blind and the other person was wandering and could display distressed behaviours. This person opened the door to go outside and was able to access a broken curtain pole which was leaning up against the dining room wall. Whilst we note staff came in to the dining area to serve the meal, the inspector still had to intervene with the person who was confused to ensure they did not harm themselves as the curtain pole was now in their hand. The other person in the dining area was unable to leave the dining arear without assistance and was noted to be swinging back on their chair and was at risk of falling if they continued to do this. A member of staff was observed to enter the dining room and stated, "Don't do that [person], you will break the chair." There was no reference to the person injuring

themselves. Three people required the help of staff to eat their lunchtime meal and the provider and deputy manager alongside care staff were noted to provide assistance to those people who were seated in the lounge. This meant there were not enough staff overall to supervise the people in the dining area who received very little engagement. This did not assure us that adequate staffing levels were available at all times to ensure peoples needs were met.

One person who had sight difficulties regularly needed assistance to go outside for a cigarette. This meant that the staff member left supporting the other people at the service at the time, would not always be able to respond to people's needs if they required more than one staff member's support after 10.00 am. The manager and deputy manager were noted to be supernumery which meant they were not included in the staff numbers allocated to provide care, however were still noted to be helping people directly and were therefore still unable to fulfil their management tasks fully. The provider was still unable to demonstrate how staffing levels were reviewed to ensure there were sufficient staff available. Staffing numbers had been calculated according to the number of people using the service rather than against individual needs which varied.

We noted that people did not have direct access to call bells within the lounge area. The provider pointed out a call bell on the wall. We noted however, the majority of people did not have the mental capacity or the ability to walk unaided to access this. Within people's rooms there were no call bell cords which would enable people to call for staff assistance if they were in bed and unable to get to access the call bell on the wall. One person told us, " I have to get up and go out to the toilet if I want to call for help." People's needs in accessing call bells had not been assessed and neither had their support needs, in accessing care or support when needed been recorded within their care plans.

We noted from a review of the last eight weeks rotas that care remained woefully low at the weekends. Whilst we acknowledge that the staffing levels had increased by one during the weekdays, the rota and discussions with the provider confirmed that there were still only two staff on duty at the weekend. There was no allocated time on the rota for handover. The provider told us that staff would come in 10 minutes early for a handover.There was no management support provided at the weekends other than telephone contact with the deputy manager. There was no cook or domestic staff provided. This meant that care staff were expected to prepare and cook meals, clean the service, make beds and manage the service. We were therefore not assured that staffing levels at the weekend were sufficient to meet people's assessed needs.

We identified that the service was in a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During a tour of the service we noted that in several people's rooms there were unstable wardrobes which had heavy items stored on top of them such as suitcases and incontinence pads. This presented a risk to people's safety of items falling off the wardrobe or the wardrobe falling on top of people. We pointed this out to the provider who told us they would rectify this immediately. One wardrobe was secured to the wall whilst the inspection was underway.

Lighting was still found to be insufficient within corridors and in some people's rooms. Corridor lighting responded to movement and would constantly turn off. The majority of people did not have bed side lamps in their rooms. We also noted that in two rooms the bathroom areas were found without light bulbs working. When we asked the provider about this they responded in one case by saying, "This person has sight difficulties." Another person who told us they liked their bathroom light on at night said, "I have asked to have it replaced, as I like it on to feel safe but it hasn't happened yet." We noted that there were several people with a sight impairment. There was no system in place for monitoring lights working throughout the

building. This lack of sufficient lighting would have impacted on their quality of life and provide a risk for them in moving around the service safely and presented a risk of falls.

We found there were insufficient infection control systems in place and the monitoring of the risks to people's health and welfare in this regard. For example, staff involved in the preparation and cooking of food wore the same uniform for providing personal care and their duties as cook in the kitchen. They occasionally put on a fabric apron but not always.

A number of infection control issues were highlighted to the provider as we toured the service. these included: Electric and emergency pull cords which were found to be dirty and soiled. Strong offensive odours in some people's rooms. A shaving razor was found in the sink in the main bathroom and people had easy access to this so were therefore at risk of harm. A communal bath slip mat was found to perished and was unclean and not fit for purpose. We found the majority of towels were found to be worn, frayed, some with holes and needed replacing. We pointed these out to the provider and deputy manager.

There were no hand washing facilities provided for staff within people's rooms. No anti-bacterial hand wash and paper towels were provided as required to ensure effective hand washing to protect people from the risk of cross infection. When we asked the provider about this they said, "Well staff wear disposable gloves." We directed the provider to refer to the Department of Health guidelines for managing infection control within care homes. This they did immediately and downloaded the guidance from the Department of Health Website as suggested, including a copy of monitoring tool for use in auditing infection control systems and practice within the service. The provider told us they had sought help from an external consultant to improve the monitoring of the service. This had resulted in the provider using checklists to monitor the service but did not ensure the provider had sufficient oversight of infection control risks within the service. The service was therefore noted to still be failing to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by not having an effective operation of systems designed to enable identification, assessment and management of the risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

There were also several fire doors throughout the service which had been wedged open. This included the main kitchen door where there was a higher risk of a fire within this area. The sound activated door opener was found to be broken. The provider told us he had purchased a new one but was waiting for the door to be painted first before replacing. We informed the provider of the need to respond to this risk as a matter of priority to ensure people were protected from the risk of harm.

We identified that the service was in a continued breach of regulation 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was evident that the provider had taken steps to improve the environment following the issue of the warning notice. For example, carpeting to corridors upstairs and the conservatory had been replaced and a new kitchen had been installed. The staff toilet had been redecorated and new flooring in place. The communal lounge had also been decorated. The provider told us and showed us new lounge chairs that had been purchased. These had yet to be put in place in the lounge. Bath and mobile hoists had been serviced. Whilst we acknowledge that the provider had made progress in improving the environment and addressing some of the staffing and infection control issues highlighted at our last inspection in January 2016, the warning notice issued had not been met in full at this follow up focused inspection.

The service had a policy and a set of procedures to support staff in the obtaining, recording, handling, using,

safe keeping, dispensing, safe administration and disposal of medicines. The staff training programme included medicines management and a competency test. We observed medication being given to people following due process and being done safely. Regular medication audits were completed to check that medicines were obtained, stored, administered and disposed of appropriately. Staff had received up to date medication training.

Requires Improvement

# Is the service effective?

## Our findings

At our inspection in January 2016 we found the service had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care. Staff were not appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people safely. The service also did not assess and monitor the quality of service provision adequately this was with particular reference to areas relating to infection control and the environment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had also found there were not sufficient, experienced staff deployed to keep people safe or assist them to receive appropriate care and support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by the end of May 2016. Whilst we found that some Improvements had been made, the provider was still not meeting all of the requirements of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found at this focused inspection there was a continued failure to ensure staff were supported with training and development to ensure they were able to deliver care and treatment to people safely and to an appropriate and required standard.

Whilst we acknowledge that training had taken place since the last inspection, most of this had been delivered in the format of staff just watching videos. It was evident from discussions with staff and the provider that there was limited dementia training for staff. The only dementia training for staff had been provided in house by the provider in April 2016. The provider told us they had last received training themselves in this subject in the year 2000. We discussed this with the provider at the time of the inspection who advised us that it would not be a problem for him to undertake an updated training course. Our discussions with staff highlighted a lack of knowledge around the different types of dementia and the care plans for people did not reflect this either.

The majority of people living at the service had a diagnosis of dementia. Care plans did not describe the type of dementia and any planning for meeting people's needs in this regard. We were not fully assured that staff could fulfil their role competently without specific guidance and support in specific conditions which related to people's predominant need in the service. At the last inspection we completed in January 2016 the manager told us a review of all staff training was required. At this inspection we saw staff had still not all been provided with current updated training that gave them the skills, knowledge and qualifications to ensure people's needs were being met. As a result the staff could still not fully demonstrate a consistent approach to supporting people.

Since the last inspection the provider had sought external support to help with the monitoring of the environment of the service. The documentation we saw showed a checklist style of audit. It did not evidence actions taken as a result of the provider highlighting areas via their own assessment of risk. We saw that the

carpets had been cleaned for instance, however there was no schedule planned for further cleaning. A broken bench in the garden also required replacement, and whilst we noted that the provider was aware of this, we were told by one person, "It's been like that for a week or so. I could not sit on it to have my cigarette yesterday so had to ask for a chair instead." There was little evidence to show that effective audits and systems were in place to identify, assess and manage any risks related to the service.

We identified that the service was in a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff understood the processes to follow if they felt a person's normal freedoms and rights were being significantly restricted. The manager carried out a mental capacity assessment at the first visit, to determine people's ability to understand their care needs and to consent to their support. When people lacked capacity or the ability to sign agreements, a family member or representative signed on their behalf. The provider or the manager met with family members and health and social care professionals to discuss any situations where complex decisions were required for people who lacked capacity, so that a decision could be taken together in their best interests. At the time of our visit there were four people subject to a DoLs.

People were very complimentary about the food. They told us they had enough to eat, their personal preferences were taken into account and there was a choice of options at meal times. Suitable arrangements were in place that supported people to eat and drink and to maintain a balanced diet. People were not rushed to eat their meals and staff used positive comments to prompt and encourage individuals to eat and drink well. The lack of staff availability to help people who required assistance meant that some people had to wait for assistance. The menu on the day of inspection looked somewhat bland with several meals provided within the week made up of processed meats. One person told us, "We get a lot of cottage pie here." We observed the carer/cook asking people what they wanted to eat for their lunch. They told people the choice was, "Pies or cottage pie." We asked this member of staff how would people know what was in the 'pies?' On a separate occasion we observed the same member of staff offering a selection of flavours of pies to another service user.

We also noted that what was offered for the midday meal was not what was described on the menu. Staff told us that apart from asking people on a daily basis their choice of what they would like to eat from the menu that it was difficult to involve people in the planning of menus.

The cook/carer demonstrated a sound knowledge in how to monitor people at risk from inadequate nutrition and hydration. A review of care records evidenced monitoring of people's weight and support for people assessed as at high risk of malnutrition. The service appropriately assessed people's nutritional status and used the Malnutrition Universal Screening Tool (MUST) to identify anyone who may need additional support with their diet such as high calorie drinks or specialist diets. These assessments were up to date and had been reviewed on a regular basis. People had been regularly weighed and where necessary referrals had been made to relevant health care professionals for issues around swallowing, or dietetic services for people with particular dietary requirements.

Requires Improvement

# Is the service caring?

## Our findings

During a tour of the premises we noted a bath and shower rota had been placed on a notice board located on the wall of the main corridor. This meant that anyone visiting the service could view this personal information. We discussed this with the provider and pointed out that this did not protect people's dignity and confidentially of information.

When speaking to one staff member they referred to them as, "[name of person] the one who is normal." When asked what they meant by 'normal?' They told us, "Well the one's without dementia." We also noted when we reviewed care plans that one person's plan referred to them being, 'smell free.' When we pointed this out to the manager they accepted that this was not an acceptable way to refer to someone and advised us that they would amend the wording.

We also noted in one person's room there was a broken curtain with only one half of a curtain up at the window. This meant that there was insufficient screening to protect their privacy and dignity. The provider and deputy manager were not aware of this until we pointed it out to them. This raised concerns with us that staff did not always respect people's dignity as they were not self aware around their actions and the terminology they used when referring to people.

We identified that the service was in breach of regulation 10 (10 and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they liked the staff and felt that they were well cared for. A visiting relative told us, "The staff look after [person] very well. In contrast to the home they came from they look after [person] a lot better. We have confidence in the staff here." During this inspection we observed attentive and positive interactions between staff and people living at Abbey Care Home.

We observed staff interactions with people throughout the inspection which showed that staff were caring and helpful. Staff demonstrated patience when supporting people to allow them to maintain a pace that was comfortable for them. For example, we saw a person being helped to mobilise along a corridor out to the garden area to have a cigarette. The staff gave instructions to the person and allowed the person to move at their own pace. We also observed care staff sitting with people in communal areas and prompting them with one to one activities, some dancing and music was playing. They interacted well with people, and also engaged people in conversations. We observed people greet people in a friendly manner to which they responded positively. We saw this was done using their preferred name.

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

Whilst we note staff were responsive to most people's requests we noted one person who was sitting in the

lounge when we arrived. Our observations noted that six hours later this person was still sitting in their chair and they had not moved in that time. Staff had engaged with this person but had not even assisted them to the toilet in that time. Whilst we note that staff were responsive to people's needs, this person was non verbal and did not have a call bell nearby to summon assistance. This did not demonstrate that staff were not fully proactive in responding to and anticipating people's needs in a thoughtful and compassionate way. We also noted that the chairs in the lounge were quite hard and uncomfortable for people to sit on. The provider showed us new lounge chairs that had been purchased. These had yet to be placed in the lounge.

In contrast other staff were seen assisting people to sit on the armchairs or stand whilst explaining clearly what they were doing. For example one staff member was observed asking one person to stand who would not stand without assistance. The staff member told us, "You have to be firm but friendly and fair with [person]." They guided the person gently as they sat back down. This demonstrated staff knew how best to communicate with people. Staff we spoke with told us they encouraged as many people to maintain their independence as long as they were safe to do so. Throughout our visit, we saw staff encouraged people to make their own decisions and prompted them to move around independently. This showed that staff promoted people's independence.

Records showed that family members had been involved in care plan reviews. We saw there was information in care plans to ensure people were referred to by their preferred name and that detailed life histories had been compiled with the help of family members. This provided staff with information about the person, which would enable them to understand people's life experiences and their wishes and choices about how they chose to live their lives.

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

Requires Improvement

# Is the service responsive?

## Our findings

At our inspection in January 2016 we found the service had not taken proper steps to ensure that they maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The service also did not ensure systems and processes were established and operated effectively to ensure compliance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider that detailed how they would meet the legal requirements. Whilst we found that some improvements had been made, the provider was still not fully meeting all of the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found at this focused inspection there was a continued failure to ensure accurate records were kept in respect of each service user which detailed fully the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Care plans were developed from discussions with people, observations and the assessment. Most care plans contained information about people's needs in relation to health, mental health, mobility aids, continence, medicines, tissue viability, personal care, diet and social interests. However one care plan for a person who had moved in 3 days before our visit had not been fully completed. There was some information relating to the management of their medicines, but apart from this the only information available to staff was contained within the pre-admission assessment, which we found did not reflect the person's current care and support needs. This was the only information staff had available to them. The deputy manager told us they were going to complete the care plan for this person on the day of our visit.

Whilst we acknowledge that most care plans described the current care needs of the people we case tracked and daily records recorded the support staff provided people, there were some exceptions to this. For example where care plans identified people who presented with distressed behaviours and extreme reactions to situations or others, there was insufficient guidance for staff in supporting people in a safe and empowering manner. For example, for one person their care plans described them as, 'verbally rude and aggressive' and, 'non-compliant' with receiving personal care. Guidance described for staff stated they had, 'to be firm but fair' and also, 'staff must be firm, this is in their best interests'. We discussed our concerns with regards to this type of recording and how this could be perceived and misunderstood by staff responsible for providing care and support. The provider agreed to review this.

Additionally two people had been cared for with in-dwelling catheters, their care plans described how often the catheter bag and valve should be replaced. However, the care plans did not clearly record when and how often this action had been taken place. Whilst we acknowledge staff were aware of people's care and knew their needs well, these were not on this occasion documented accurately. This did not also provide us with assurance that people had been protected from the risk of acquiring infections associated with

insufficient catheter care monitoring because an accurate record of care had not been kept.

Care plans therefore lacked information about people's preferences and wishes about how they wanted to receive their care and support and what people could do for themselves and what support they required from staff in relation to their personal care, in order to develop or maintain their Independence. For example one care plan we reviewed stated that, '[person] requires assistance with personal care and one carer', but did not specify any choices or whether the person's independence could be promoted as it was not clear how much they could do for themself. The provider has therefore failed to maintain an accurate and complete record in respect of each service user, including a record of the care and support provided to the service user and decisions taken in relation to the care and support provided.

We identified that the service was in a continued breach of regulation 17 (1) & (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were very happy with the care and support they received and felt it met their needs. One relative told us they had visited the service prior to their relative moving in, to have a look round. Care plans contained a copy of the pre-admission assessment undertaken by the manager. This information, observations during the visit and discussions with family members was used to ensure that the service was able to meet people's needs.

Staff demonstrated that they knew people and their needs well. They were able to talk about people's current care and support needs in detail. Most care plans had been reviewed within the last six months by staff. In addition some people were visited by external healthcare professionals and their care and support reviewed at least annually by the community mental health team. One visiting healthcare professional we spoke with on the day of inspection stated they had no problems with the service and were confident any care instructions for people at the service, given to the staff would be carried out appropriately.

The service did not have an allocated activity co-ordinator. We saw that an extra member of staff had come in and was playing scrabble with one person. They told us when they had free time they would come in and do activities with people and that this was unpaid work. We saw photos of recent activities and music was playing in the lounge. This was an improvement on our last inspection and we discussed the need for meaningful activities to be a more integral part of the day with the provider. We saw staff engage with people in conversation and the atmosphere in the service was jovial. People could choose to stay in their rooms or sit in the lounge if they so wished. We will look at this area in more depth at the next comprehensive inspection of this service.

People using the service and relatives said they knew about the service's complaints procedure and they would tell staff or the manager if they were unhappy or wanted to make a complaint. They said they were confident they would be listened to and their complaints would be fully investigated and action taken if necessary. We saw copies of the complaints procedure displayed throughout the home. One person using the service said, "I have no complaints but know who I would talk to if I had." We saw a complaints file that included a copy of the provider's complaints procedure and forms for recording and responding to complaints. Complaints records showed that when concerns had been raised these were investigated and responded to appropriately and where necessary discussions were held with the complainant to resolve their concerns.

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 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The registered person did not ensure that all service users were treated with dignity and respect.<br><br>Regulation 10 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider did not ensure that they maintained an accurate and complete record in respect of each service user, including a record of the care and support provided to the service user and decisions taken in relation to the care and support provided.<br><br>Regulation 17 (2) (c) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered person did not ensure that care and treatment was provided in a safe way for service users at all times in relation to staff training, the environment and infection control in in order to meet the provision of the regulated activity.<br><br>Regulation 12 (1) and (2) |

**The enforcement action we took:**

We imposed a positive condition on the registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered person did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in order to meet the provision of the regulated activity.<br><br>Regulation 18 (1) |

**The enforcement action we took:**

We imposed a positive condition on the registration