Mrs M Ghouze

The Birches

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 June 2016 and was unannounced.

The Birches is a residential home which provides care to older people including some people who are living with dementia. The Birches is registered to provide care for up to 19 people. At the time of our inspection there were 15 people living at the home.

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

At our previous inspection in February 2016, we rated the home as inadequate and that the service was placed into special measures.

We asked the provider to take action to make improvements. They sent us an action plan that all the improvements would be in place by 31 March 2016.
At this inspection we looked to see if the provider had responded to make the required improvements; we found some areas of improvement, however in some areas further improvement is needed to ensure compliance with some regulations. We found there was a lack of management oversight by the provider to check delegated duties had been carried out effectively. The quality monitoring systems included reviews of people's care plans, health and safety checks and checks on medicines management. These checks and systems were not reviewed by the provider or registered manager to ensure people received a quality of service. Accidents, incidents and falls were recorded but not analysed to prevent further incidents from happening. Improvements were required in assessing risks to people and how staffing levels were determined to ensure safe levels of care were maintained to a standard that supported people's health and welfare.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. There was no system by the provider to supervise or oversee the registered manager and how they ensured people were safe in the home.

Health and safety checks were not always completed to ensure risks to people's safety were minimised. We identified some health and safety issues to the registered manager and the provider on the day of our inspection visit where we had immediate concerns to people's safety.

Risks to people's health and welfare were identified but not effectively managed and where people were at risk of harm, actions had not been taken to keep people safe. Care plans provided information for staff that identified people's support needs and associated risks. However, some care plans and risk assessments required information to be updated to ensure staff provided consistent support that met people's changing

needs.

There were not enough staff on duty at night to respond to people's health needs and to keep people safe and protected from risk. The registered manager had no dependency tool to establish safe staffing levels so there was no effective formula that calculated what those safe staffing levels should be. Further improvement was still required in staff recruitment procedures to ensure people were cared for by staff who had been assessed as safe to work with people.

At the previous inspection in February 2016, we found people were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). At this inspection there were some improvements in how people's capacity was determined, but further improvements were still required. Mental capacity assessments were completed but these were not always decision specific and records of those involved were not always completed. One person had a DoLS in place at the time of our inspection.

Staff knew how to keep people safe from the risk of abuse. People told us they felt safe living at The Birches and visiting relatives felt their family members were safe and protected from abuse.

People felt cared for by a caring staff group. Staff understood people's needs and abilities and received updated information at shift handovers. Staff training was completed, but not all staff had received training to update their skills. Staff that identified a training need did not have this provided.

People were provided with meals that met their cultural and dietary needs. Health professional advice was sought for all those at risk of malnutrition and dehydration. Staff ensured people obtained advice and support from health professionals to maintain and improve their health.

People said staff provided the care they needed. Care was planned to meet people's individual needs and abilities. Care plans were reviewed although some information required updating to ensure staff had the necessary information to support people as their needs changed.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were at risk from harm as staff did not ensure all areas of medication administration was safe. People said they were supported with their medicines, though the administration of medicines was not consistently secure and written instructions to ensure medicines were given accurately were not always in place.

The safety of premises had improved with strengthened glass and window closers being fitted. However other areas of environmental safety still required to be made safe, and some new areas were highlighted. Policies and procedures had not been updated to include information for staff to ensure policies were followed consistently. Periodic tests of the environment were recorded by staff and some were undertaken by external experts.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some staff had completed essential training to meet people's needs but this was not always updated to ensure staff were in receipt of the latest guidance on best practice. Where there was conflicting information about people's capacity to make specific decisions, mental capacity assessments had not always been completed. People were supported to maintain their health and referred to external healthcare professionals when a need was identified. People, who were restricted from leaving the home alone, did not have the terms of the DoLS restriction met by staff.

Is the service caring?

Requires Improvement

The service was not caring consistently. Staff provided care in a kind and sensitive manner; however there were times that people's individual needs were not attended to. People told us when staff spent time with them, staff were caring and understanding.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their families were not always involved in planning or reviewing how they were cared for and supported. Staff understood people's preferences, likes and dislikes. There were few choices of activities and pastimes to ensure people were stimulated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some quality assurance systems are in place but required better organisation to ensure improvements that had been identified, resulted in positive actions being taken. Records of tests were completed by staff, however these were not overseen by the provider or registered manager to ensure any shortfalls that were picked up, were put right and did not endanger the safety of those in the home. The provider's risk assessments of the premises had not identified potential risks to people and regular maintenance checks were not effective. This meant that a number of shortfalls continued in relation to the service people received.

The Birches

Detailed findings

Background to this inspection

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

This inspection took place on 20 June 2016, and was unannounced. The inspection team consisted of two inspectors.

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

This inspection was to check improvements had been made since the February 2016 inspection. We asked the registered manager and provider to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the home following our last visit.

We spent time observing the care being provided throughout the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three people using the service, four visiting relatives, the provider, registered manager, three care staff, and cook. Following the inspection we received additional information from the registered manager and spoke with night staff that we were unable to speak with on the day of the inspection.

We looked at the notifications from the provider; a notification is information about important events which the service is required to send us by law.

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

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 12 February 2016, we asked the provider to take action to make improvements and ensure that proper policies and procedures were in place to enable medicines to be administered accurately and at appropriate times. The provider sent us a plan that identified the actions they would take to be compliant with the regulations by 31 March 2016.

Staff had not realised one person's medicine was missing from the new monthly supply and not available for administration. We looked back at the previous month's medication administration records (MAR) and saw the staff had recorded the person had 'not required' all the previous month's supply. When we checked the medicine returns, we found they had not been returned to the chemist for disposal. We reported this to the registered manager so she could take appropriate action to find these medicines. The registered manager informed us that they could not account for the missing medicine and reported this to the police. There was no procedure for staff to follow to enable them to safely store, administer and dispose of medicines.

Staff recorded when medicines were not administered but did not use the codes identified on the MAR consistently. For example, if a person was asleep, staff were instructed to use a 'S' on the MAR record, however we found that some staff were using 'S' when the person was ill [sick]. Similarly staff used 'O' when medicines were refused when they should have used 'R'. Inconsistently recording information into the MAR chart, had the potential for confusion over what and when medicines were given.

The registered manager had arranged a sheet of staff signatures to indicate which staff administered medicines however this did not include the staff's initials. That meant it was not possible to ascertain which member of staff had signed to confirm medicines had been administered.

We saw there were still some missing guidance protocols for PRN or as 'required medicines'. These are important as they provide staff with accurate guidance when and how often to give these medicines. This was also highlighted at the last inspection in February 2016. We discussed this with the registered manager who said she had delegated responsibility for the medicines administration to another member of staff and would speak with them and ask the reason for the omission.

The policy for safe storage and administration of medicines had not been updated since October 2015. The current policy seen, did not include any information on how the systems in use were audited. There was no medicines procedure to accompany the policy and to ensure staff were informed of the administration process. These issues were highlighted at the last inspection.

People told us they received their medicines on time, and in a way they could take them. Medicines were delivered from the pharmacy in colour coded blister packs, which included their name and photo of the person which confirmed their identity. Colour coded blister packs denoted which times each medicine should be administered. All medicines were kept in appropriately locked cupboard and any that required cold storage were kept in a medicine fridge. There was a thermometer and record of medicines storage temperatures in the trolley. The temperature records had not been completed consistently, but the records

that had been completed were within levels that ensured that the medicines remained potent. The registered manager said she would ensure staff would start recording the temperatures on a daily basis. Liquid medicines were marked with the date the medicine was opened, which ensured they were administered or disposed of within their expiry date.

Staff received training to ensure people's medicines were administered appropriately and staff who administered medicines told us the registered manager carried out observations of their practice to ensure they continued to administer medicines safely.

At the last inspection on 12 February 2016, we asked the provider to take action to make improvements and ensure that where people were potentially at risk from harm, that this was thoroughly assessed to protect them and minimise the risk.

People told us they felt safe, one person said, "I am safe, the staff are like family." A relative told us, "[Name] is safer here than at home on her own."

Care staff were confident that people were safe from harm and said they would report any concerns of abuse to a registered manager or deputy. They were aware how to contact external agencies such as the local authority safeguarding or CQC and said they would do so if they felt their concerns were not dealt with. Records showed that care staff had completed training on how to keep people safe and staff we spoke with confirmed they had been provided with relevant training and guidance.
The staff we spoke with had a clear understanding of the different kinds of potential abuse, and most told us they had received training on how to protect people from abuse or harm. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had happened within the home. The most recently employed member of care staff still had to undertake their safeguarding training. One member of staff said, "If I suspected abuse, I would speak with the registered manager, then if there was no improvement I would call social services or CQC. All of the staff we spoke with were aware of whistle blowing, and said they had not seen anything that required reporting or gave them cause for concern.

The registered manager said there was a policy and procedure for safeguarding people, and this was due to be updated in line with the new information the provider had obtained. The registered manager told us they would refer any incidents of abuse to the provider, local authority and CQC. We looked at the policy but this was still in a 'draft' form and had not been personalised to include details about the home.

We looked at the systems in place to minimise the risks associated with people falling and what actions had been taken as a result. Some people we spoke with told us they had fallen whilst living in the home. Also prior to this visit, the provider had notified us about a serious injury that resulted from a person falling and subsequently being admitted to hospital. We looked at records and found that there had been a number of falls. We were concerned the registered manager had not taken action to assess why people who were identified at risk of falls, were falling, and what interventions could be taken, to minimise the risk of further falls and potential injuries. The registered manager had risk assessments in place for people using the service, but these were not well detailed or up to date. We asked the registered manager if she had performed a falls audit to analyse any patterns so contingencies could be put in place. The registered manager said there were no audits in place.
We looked at two people's care records, for those who were identified at risk of falling. Between the periods of 12 February 2016 and 21 June 2016, one person had fallen 19 times. Staff knew this person was at risk of falling and said they always kept this person within eyesight to reduce the falls risk. This person had been referred to the falls clinic and the frequency of falls had reduced.

In the same period another person had fallen 11 times. There was a delay in referring this person to the falls clinic and the registered manager told us there was a delay in staff recognising the pattern of falls. They then awaited a GP to agree the referral. We asked what measures had been taken to reduce the falls for this person from happening again. We were told an alarm mat was in place and staff made sure this was turned on when the person was in bed. The registered manager told us training for staff in safe moving and handling was being planned to ensure staff knowledge remained effective and kept people safe.

A relative told us their relation had a mattress on the floor of their bedroom to cushion a fall from their bed, but this was removed and bed rails put in their place. They felt the mattress was an inadequate means of keeping their relative safe and protected, as the special bed the person used could be lowered near to the floor. We asked the registered manager why the mattress had been removed and we were told as it was a trip hazard for the staff and the bed rails were put in place instead.

The registered manager told us that care staffing levels to support 15 people were three care staff mornings, afternoon and evening reduced to one waking and one on call care staff at night. There were no regular assessments to ensure that staffing numbers were sufficient to meet people's individual needs and ensure people were safe. We looked at the caring duties that night staff had to undertake, and ascertained one waking member of night staff was not adequate to enable the safe moving and handling of people, as two people were required to safely undertake this task. The registered manager could not confirm staffing levels reflected people's needs, as the care plans and risk assessments did not fully reflect the support they required.

A cook and housekeeper were also included on the rota and the care team were supported by the part time registered manager and their deputy. There were currently no processes in place, for making sure that staffing levels were adequate, and the right mix of staff with the required skills, competencies, qualifications, experience and knowledge, were available to meet people's individual needs.

At the last inspection on 12 February 2016, we asked the provider to take action and make sure people employed by the service had the appropriate clearances and checks in place prior to commencing employment.

We looked at the recruitment file for one person employed at the home since our February 2016 inspection. They had gone through a detailed recruitment process, had been interviewed and references obtained. The registered manager used the disclosure and barring service clearance (DBS) from the person's previous employer, believing this was portable, and usable in the recruitment process. Where a person commences another employment within a year of the DBS being issued, this can be used by the new employer. However in this case the registered manager had not checked and this was out of date by three months, and a follow up check had not been applied for. We spoke with the registered manager about this who explained that she was not aware of the time limit that DBS clearances remained 'in date'.

At the last inspection on 12 February 2016, we asked the provider to take action and make sure the cleaning schedules were brought up to date and informed staff how to protect people in the home from cross infection and cross contamination. The provider sent us an action plan that they would be compliant by September 2016 we will look at this on our return to the service.

Some routine tests of the fire and evacuation system, water sampling, electricity, gas, hoists and stair lift were undertaken by experienced and qualified companies external to the home.

Staff told us they had completed training courses on chemicals and control of substances hazardous to

health (COSHH). We found that most cleaning chemicals were locked away, except the cleaning fluid we found in the first floor bathroom. COSHH data sheets were in place to inform staff the correct procedure in the event of an accident with these chemicals.

At the beginning of our visit, the registered manager walked us around the home. They showed us the windows that had been made safer by the addition of safety glass and addition window closers. That meant the overall safety off these windows had improved. The registered manager told us they walked round the home on a daily basis to make sure any risks or maintenance issues were identified so any potential risks to people could be minimised. Walking around the home, we found some health and safety issues that could have potential to cause serious injury. There was a carpet shampooer and shampoo in a bathroom, and an iron left in the corridor outside a bedroom. We asked the registered manager why these had been left there. She stated the carpet cleaner was stored in the bathroom, but was not aware why the cleaning fluid or the iron was left accessible by people who lived in the home. Both items were removed during our inspection.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 12 February 2016, we asked the provider to take action to make improvements and ensure that people were asked to consent to the care and treatment offered to them. The provider sent us a plan that they would be compliant with the regulations by 31 March 2016.

We spoke with people's relatives about being involved in decisions on behalf of their relative. One person said that they had power of attorney for their mother, but staff would not listen to suggestions they made to improve their mother's wellbeing and safety. We spoke with the registered manager about this, who agreed to find out the extent of the power of attorney that had been granted, and arrange updated capacity assessments for the person. The registered manager acknowledged that they would work with this person and their family to ensure their needs and preferences were fully assessed and met.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

Mental capacity assessments were not always in place for people who had varying capacity or lacked capacity to make certain decisions. The registered manager was aware that one person's son had power of attorney in place. However they were not aware if this was for health and welfare or financial support or both. This is important as the staff need to be aware of the restrictions placed on this person to ensure they offer them the correct support and choices.

We found where people lacked capacity to make an informed choice; the information was not always decision specific which meant staff may not provide a consistent approach when supporting people with their decisions. The registered manager said they had not had any further training on the MCA, and was still unsure when mental capacity assessments should be undertaken, to aid people's decision making.

Records of best interest meetings and any decisions had not been recorded. It is a requirement to record best interest meetings and mental capacity assessments. The registered manager confirmed families were involved but was unable to support this with a capacity assessment, records of best interest meetings or decisions.

We spoke with a number of staff, who had undertaken MCA training. We could not be sure all the staff fully understood the principles of the Act, as some were unsure of what they could legally prevent people doing to ensure their safety. Staff were able to explain that choices were given to people prior to a task being undertaken. Staff were aware that people were presumed to have capacity to make decisions unless proven otherwise. Staff told us, where people lacked capacity they still offered choices. Throughout the inspection

we heard staff explaining to people and seeking their consent before commencing a task. One member of staff said, "It's about getting people to understand what we are offering, and making sure they understand before we go ahead."

We saw that people had consented to care by signing forms for areas such as personal care, medicines, sharing information and taking photographs. These had not been updated recently and it was not clear people still had capacity to do so.

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

At the last inspection on 12 February 2016, we asked the provider to take action to make improvements and ensure that people were safeguarded from abuse and improper treatment.

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). At the time of our inspection, one application had been approved by the local authority to make sure people's freedoms were not unnecessarily restricted. We found that another person was being cared for in bed with bedrails which restricted their movement, but again no DoLS application had been made. The registered manager told us they were placed there for the person's safety, and agreement was sought from the person's relative, as the person had fluctuating capacity.

We found the person who was being cared for in bed and had bed rails in place, had varying capacity. The registered manager had not completed a capacity assessment to confirm their level of capacity. At the time of our inspection, the registered manager was unsure if the person's relative had power of attorney (POA) over their care and welfare, finances or both. The registered manager explained that they had not referred the person for a Deprivation of Liberty Safeguards (DoLS) as the POA was in place. Following the inspection we became aware that the person had power of attorney for finances only. That meant it was the responsibility of the provider and registered manager to act accordingly and begin the DoLS process. To ensure the person was supported and received effective care.

We looked for an updated policy on the use of bedrails, but we could not find one. We also looked at the DoLS folder, but again there was no written policy or procedure to inform staff of the correct application process. We asked the registered manager about these, and were told the provider had purchased new 'paperwork' from a company. We understand these to include policies and procedures for the running of the business. The registered manager explained that these had only been obtained recently and none had yet been implemented. That meant that due to delays in updating or implementing new policies and procedures, there was a failure by the provider and registered manager to monitor and protect people from the improper use of restraint.

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

The registered manager was still unaware of the full extent of DoLS legislation and what that meant to people in the home. That does not provide assurance that the provider supports people's rights and freedoms in the home.

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

People told us the staff were attentive, one person said, "They look after me well, I like to play bingo and stuff." We received mixed comments from relatives about the home, one said, "Staff are very good, approachable and not a problem at all," another said, "There appears to be enough staff, no one is kept waiting for anything." However another said to us, they believed their family member received care and support which was "Barely adequate." The person followed the comment up by comparing the care provided to the cost of the fees charged. They also added their relative was settled, and neither they nor their relative wanted to move.

Staff told us that they had supervision meetings with the registered manager or their deputy about every 6 to 8 weeks. Supervision is linked to staff development and uses and exchange of information to drive change and improvements in the home. The registered manager told us that staff supervision was used to ensure staff had no problems and to look at their training and appraisals and she planned staff supervision every two months. At the last inspection in February 2016 staff supervision included observed practices of staff completing tasks such as medication administration.

Staff confirmed they received regular supervision sessions and discussed topics relevant to the home, they also said they discussed training needs. However one member of staff recognised that they would benefit from challenging behaviour training over a year ago and this had still not been organised. The member of staff told us that would have helped them care for people who have presented with such behaviour due to their condition.

Staff told us that during these meetings, they did not discuss individual peoples' needs or the development of peoples' care plans and risk assessments. That did not demonstrate supervision was targeted towards developing the care people required. We asked for a policy and procedure to see what the provider expected that supervision would include. The registered manager told us there was no current policy but the provider had purchased new policies which would now be put in place. Staff supervision meetings were not used to inform and update information in care plans and risk assessments, with useful information being exchanged between care staff and management.

People's needs were discussed at handover between the change of shifts, however this was not recorded or used to inform or update people's care plans or risk assessments. That meant the information exchange between people was not recorded so staff that were not on shift could not learn from the updated information.

Staff told us they had received training to do their job. We looked at the staff training records and saw staff had attended training however a number of courses were out of date. Three staff had completed tissue viability training, however this did not include any 'senior' care staff or the registered manager. There was a similar situation with health and safety training, where three staff were trained in 2013, one in 2014 and one in 2015. That meant that the remaining 11 staff from the total group had no training at all. Staff had not attended any specialist dementia courses or dementia activities training which would have benefited the current client group. The registered manager was not aware of the training, or the need for staff to undertake this specialist training. This meant we could not be assured the needs of people are met consistently by staff who have the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours.

People and their relatives we spoke with were happy with the quality of food. Comments included, "The food is very good," and "The food is not bad and they give you enough. We always get a choice if we don't like the main meal." One person commented during the lunch time meal, "That fish was lovely."

We observed what support people were offered during their lunchtime meal. We overheard one member of staff who asked one person which type of drink they required with their lunch, offering a choice of three. There was one main meal on offer at lunch time. We saw the cook produced alternative choices for three people that did not want the fish pie. The cook said they knew people's choices because staff had asked them earlier in the day. We saw the cook brought a sweet trolley which contained a selection of five hot and cold choices for dessert. At that time one person said to them, "Thanks (named) that fish was lovely." The cook told us they received information about people's dietary needs so they made sure people received their foods in a way that did not put them at risk.

We found people's weight was measured and recorded. Where people were unable to stand to be weighed the registered manager had obtained information from the district nurse, which enabled people's weight loss or gain to be monitored. People had been referred to their GP and other medical professionals such as dieticians and speech and language therapists, where concerns about people's food or fluid intake had been identified.

Staff were able to tell us about people that required changes to their diet. Information in care plans detailed people's dietary needs and people were provided with meals that met their cultural and dietary needs. Some people were referred to healthcare professionals to ensure the appropriate dietary information and choices. For example in one file was saw the person required a fork mashed diet and the information was recorded in a risk assessment. That meant staff had the appropriate information about people's dietary requirements.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were caring and responsive. One person said, "I am happy here, they take care of me."

Visiting relatives we spoke with commented, "I can visit whenever I want, there's no restrictions," and added "Staff are friendly and it's a relaxed atmosphere." Another relative said, "I feel the atmosphere has improved greatly since your last visit (inspection)." A member of staff said, "There is a lovely atmosphere in the home."

We observed staff interactions with people throughout the inspection which showed that staff were caring, helpful and people were treated respectfully. Staff demonstrated patience when supporting people to allow them to maintain a pace that was comfortable for them. For example, we saw a person being helped to mobilise from a wheelchair into the lounge. The staff gave instructions to the person and allowed the person to move at their own pace. We observed care staff interacted well with people, and engaged some in conversation.

The manager and senior staff understood and promoted respectful and compassionate behaviour within the staff team. Staff told us this was discussed at staff meetings and it was an accepted part of caring for people.

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

We saw that there was now information regarding independent advocates available at the service. An advocate can assist people who have difficulty in making their own, informed, independent choices about decisions that affect their lives. We discussed advocacy with the registered manager who confirmed that one person had used the services of an advocate. This was to assist their transfer to a care home with nursing, and was arranged by the hospital on behalf of the person.

Throughout our visit we saw that people were able to make choices about how and where they spent their time. We observed staff knocked on people's bedroom doors before entering and when staff offered people personal care they closed doors which meant staff recognised and respected people's privacy and dignity. We saw one person was getting anxious and requested staff assistance to receive personal care. We later learned the person was capable of walking to the toilet, but requested assistance to preserve their dignity. Staff showed concern for people's wellbeing in a caring and meaningful way, and responded to their needs quickly.
We observed a member of care staff who assisted a person using the service, to eat their lunch. The member of staff ensured the person's clothes were appropriately covered, assisted them at a pace to suit the person, and ensured their dignity by wiping their mouth of excess food. That demonstrated staff were aware how to best assist people whilst their dignity was recognised.

Staff we spoke with told us they encouraged as many people as possible 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. For example we saw where staff prompted people to walk to the dining and remained at a safe distance to give encouragement and friendly instruction.

Though we found the staff were caring and respectful to people, the lack of regular opportunities for people to engage in meaningful activities detracted from the overall caring ethos. We found there were no regular activities offered by staff in the home. There was a reliance on a volunteer to assist with activities, but the volunteer had reduced the amount of time they could devote and staff had not taken up the short fall. We could not find records where staff assisted people with any activities. At the last inspection we saw staff playing a floor game with people, however on this visit there was no activities being undertaken.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 12 February 2016, we asked the provider to take action to make improvements and ensured that staff listened to people and provided the care they required to meet their individual circumstances. The provider sent us a plan that they would be compliant with the regulations by 31 March 2016.

We spoke with people in the home, and one person said, "Staff look after me really well."
One relative said they thought the staff were, "Very respectful and attentive, but not well organised." Another said, "We were involved in the review of the care plan, but have not seen it recently." And another said, "There's also been an increase in staff too and when people ask for things staff are quick (at responding)."

People and their relatives told us they received the care and support they needed to maintain their daily lives. One person and a visiting family both confirmed they were involved in decisions about their or their relative's care and we saw that they had signed their care plans and risk assessments to confirm their agreement with the care being offered.

However, we found examples of where people's care based on their personal and individual needs, were not being planned for or met. Care plans did not consistently reflect how people would like to receive their care, treatment and support. We looked at the conditions placed by the local authority on a person whose liberty was restricted by a DoLS. These specified that that the person should be supported to go out for regular walks, have meaningful activities and be provided with written communication to aid choice. Current staffing levels did not support this person to receive these care needs consistently. The manager told us; "We can't support [him] to go out we only have three staff." We looked at the person's care plan, which did not support or reflect the DoLS conditions. We asked the provider and registered manager about this person's DoLS conditions. Both stated they were unaware that any conditions were in place.

We looked at the care plans and risk assessments, which have been updated since our last visit, and were now being transferred onto a new computer format. The provider has recently purchased a computer based records system for care records and policies and procedures. The registered manager said this new format would help when the care plans were being reviewed, as changes could be made and the plan re-printed.

We spoke with four care staff who demonstrated they were aware of people's individual needs. However when we looked at four care plans, we found inconsistent information and not everyone had been involved in how their care was planned. Staff told us not everyone was interested in signing their care plan to demonstrate they were knowledgeable about the care being offered. However there was no record that people had been asked, nor was there any auditing of people's care plans which would have revealed this.

Another family told us they had signed their relative's care plan some time ago, and added they had not been approached recently to agree the most recent care plan. Care staff also told us they were not involved when care plan were updated That is important because care staff are in day to day contact with the people using the service, and can provide detailed information to assist the process. That demonstrated that care

plan reviews were not performed regularly using people who could best provide information to ensure a consistently evolved care plan.

We spent time observing the staff interaction for a person cared for in bed, who required two hourly turning to avoid the risk of skin damage. Staff recorded when the person was turned and was offered food. When we spoke with the person they said, "They [staff] don't come in very often, they sometimes sit and chat when they have time," and added, "Sometimes there's a drink there, sometimes I can't reach it." We looked at the care plan for this person, which did not guide staff to ensure drinks were available following a change in their position. Staff were not always responsive to that person's needs or providing care in a person centred way and their care plans failed to reflect how they would like to receive their care, treatment and support.

One person's relative had asked if their relative could have more stimulation. We looked but could not find an activities programme for people. Staff told us that since the voluntary activities person reduced their attendances, there were few activities that took place regularly. One relative felt there were not many opportunities for people to get involved in activities. They told us, "Not many activities, no timetable and no trips out that I am aware of." We did not see the staff attempt to engage anyone with activities in the time we were in the home. We did see a visiting student spend time with people and sat and chatted with them.

We spoke with the registered manager about the provision of activities in the home. They agreed there was not a programme designed by the staff to allow people access to activities and no specific activities for people living with dementia. Activities are important to ensure people are provided with person centred events and are stimulated to reduce the effect of social isolation.

One relative commented, "The staff are welcoming, I have no complaints, if I did I would tell the lady with the blonde hair (registered manager)." Another relative commented, "I think things have recently improved, it's good to see [name] out of bed, as it was quite depressing when she was isolated in her room." And another, "No complaints I would just have a word with Carol (registered manager)."

We saw the registered manager had received one complaint in the last 12 months, this had resulted in disciplinary action against a member of staff. That meant there was evidence the service effectively responded to people's concerns, investigated complaints and took appropriate action to deal with concerns. Learning from this incident was fed back to staff through staff meetings so they could improve their practice and so the care for people in the home. The provider's complaints policy was located outside the ground floor office. We looked at the complaints policy and procedure, which had been updated and included details of the local authority, which are the appropriate body to investigate complaints.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 12 February 2016, we asked the provider to take action to make improvements and ensure that systems were established and operated to ensure compliance with the regulations. There were not effective systems in place to regularly monitor the quality of the services provided to identify, assess and manage risks relating to the health, welfare and safety of people using the service. The provider sent us a plan that they would be compliant with the regulations by 31 March 2016.

At this inspection we found areas that we previously identified as inadequate and required improvement had not been sufficiently addressed. We found the provider's audit processes to monitor the quality of the service provided, were ineffective and insufficient to ensure people consistently received safe levels of care.

At this inspection we found the provider had introduced some audit processes to monitor the quality of the service. We asked the provider how they monitored and oversaw the quality audits that had been introduced. They told us they did not, but expected the registered manager to undertake these. The provider then turned to the registered manager and asked, "We do this don't we?" The registered manager replied, "It's something we have never done." The provider replied they did not know and recognised there were many which were not in place.

We found people had fallen in the home, but the registered manager had only informed us of one fall which resulted in a serious injury to the person. There had been no overall analysis of accidents that had taken place. We found when people had fallen, a review of their falls risk assessment had not taken place to consider whether actions were needed to reduce the risks of reoccurrence.

Speaking with the registered manager and reviewing their systems we identified a lack of proactive management and leadership which affected the quality of service provided. For example, we looked at the processes the registered manager used to make sure people received safe and effective care, from staff who were trained and qualified to provide that care. The system that monitored training had not been updated for some time. We asked for a copy, and were provided with a training schedule that showed only eight of the 16 staff had received manual handling training within the past 12 months. There were other significant gaps in training, with only five staff that had recent training in safeguarding and four in MCA and DoLS. The registered manager had not undertaken any refresher courses in these subjects, which meant it was not possible for them to monitor staff to ensure a quality service was being offered. We asked the registered manager for a plan of supervision but said they had no specific programme to adhere to. That meant there was no clear staff development plan to ensure staff training was up to date and positively affected people in the home.

We spoke with the registered manager about the systems they used to assess monitor and improve the quality of services provided in the home. For example, we looked at the conditions set by the local authority for a person whose freedom was restricted by a DoLS being in place. Neither the provider or registered manager were aware of what was required to be put in place to ensure the person's liberty was recognised, and staff supported the person.

We looked at the process they used to make sure people received their medicines. Medication audits were done by the senior care staff approximately every three weeks. These had revealed some discrepancies in the recording system, but these had not been audited by the provider or registered manager and nothing had been put in place to rectify the shortfalls, which meant that people had not been given their prescribed

medicine.

Health and safety checks were not always effective to ensure people remained protected, and the environment was safe. Staff reported maintenance issues and these were followed up and rectified where required. The care staff were responsible for completing water checks and we found some communal bathroom areas recorded water temperatures nine – 10 degrees higher than safe limits. We asked the registered manager about this and they were not aware safe limits were exceeded. We asked to see their policy and procedure on how often and how staff should undertake the hot water tests. The registered manager admitted there was no guidance in place.

The registered manager told us they did a daily walk around the home, and had done so prior to our inspection. That had not identified the concerns we found during our visit. We asked why these issues had not been found and they could not give us a reason. We saw there was a repairs book in place; however this did not provide an appropriate means of assessing, monitoring or mitigating risk in the home. The lack of attention to ensure the environment remained safe for people had potential to place people at unnecessary risk of harm.
Through analysis of the records we saw that the registered manager had not completed any training for health and safety, first aid, food hygiene, tissue viability, safeguarding or medication administration. This meant that any supervision by the registered manager was not using the latest information or techniques and could place people at risk in the home. The registered manager had completed training for infection control and MCA and DoLS in 2013 and moving and handling in 2015.
The policies and procedures had not been reviewed recently, and many were out of date and did not reflect the current best practice or the changes in the law that governs health and social care services. We found the provider and the registered manager had not kept their knowledge up to date or accessed information from experts or other agencies about best practice and changes in regulations. For example there was no mention in the policies or procedures with regard to the Human Rights Act, MCA or DoLS legislation. That meant people may be detained unlawfully in the home.

The registered manager said the provider visited the home occasionally but they did not undertake any system of checks or audits in the home. The registered manager added there was no formal system of supervision by the provider. This did not demonstrate the provider had a system that ensured the quality and safety of those using, visiting and working in the service. A supervision policy has still to be formulated and put in place, to indicate how often supervision should take place and the structure of these sessions.
The provider and registered manager lacked insight into the safe and effective running of the home, which impacted on the quality and safety of the service offered. Quality assurance and governance are not used effectively to drive continuous improvement in the home.
This is a continued breach of Regulation 17(a) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the provider issued questionnaires to people using the service and relatives on a six monthly basis. These could be used to gather information about the home, and allowed people to suggest improvements. We spoke with the people in the home and their visiting relatives, none of whom could remember the last time they were given or sent a questionnaire.

At the last inspection we recognised the registered manager had no formal management qualifications and told us she had not planned to seek any. That meant the registered manager still relied on the provider to drive change, something which they still failed to undertake.

It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that a

service displays their most recent rating. On the day of our inspection we saw the rating from the previous inspection from February 2016 was on display outside the ground floor office.

Prior to our inspection visit we contacted the health care professionals involved with the people who used the service. The local authority had commenced visits to the home to ensure people placed there received a good service.

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 11 HSCA RA Regulations 2014 Need for consent Information was not provided in a way people could understand and consent to care being offered. Regulation 11 (1).

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 There was a failure by the provider and registered manager to monitor and protect people from the improper use of restraint. Regulation 13 (1)