Leonard Cheshire Disability

Greenhill House - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 9 and 10 December 2015 and was unannounced. The last full inspection took place in December 2013 and two compliance actions were issued in relation to the safety and suitability of premises and records. These compliance actions were followed up as part of our inspection.

Greenhill House is a nursing home with a total of 37 beds. The home is split between two individual units'; one providing residential care and the other providing nursing care to people living with physical disabilities. The home also offers day care for up to five people each week day.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

The quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people who used the service. The compliance actions issued at the last inspection in December 2013 had not been met.

The home was not suitably clean. The hygiene practices of staff did not meet the Department of Health

guidance for the prevention and detection of infection.

There were not sufficient numbers of staff to support people safely. We had feedback from staff, people and relatives that the current staffing arrangements did not meet the needs of people using the service. This was supported by our observations.

Care was not consistently person centred. Not all care plans were personalised and contained individual information and references to people's daily lives.

Risk assessments did not always reflect actions required to reduce risks to people. We saw that appropriate action was not taken in response to unsafe incidents, including steps to reduce the risk of them reoccurring.

The administration of medicines was not in line with best practice.

The provider did not have an effective system to monitor records made by staff or records that related to the management of the service. Records used to monitor people's health and record best interests' decision making were not always completed.

Training in the Mental Capacity Act 2005 had been provided and staff were knowledgeable about the protection of people's rights. Despite this the provider had failed to ensure that best interest decisions were reviewed as expected.

We received positive feedback about the care staff and their approach with people using the service; however we observed occasions when people's dignity had been compromised.

Staff appraisals and supervisions were not undertaken as planned. The registered manager failed to monitor and feedback on staff performance.

Staff felt that their views and concerns would be listened to but were not confident these would be acted upon.

Deprivation of Liberty Safeguards applications had been made for those people that required them. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

The provider had made appropriate notifications to the Commission; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

People had access to healthcare professionals when required, and records demonstrated the service had made referrals when there were concerns.

Appropriate recruitment procedures were undertaken.

The provider had a complaints procedure, and people told us they could approach staff if they had concerns.

We found six breaches of regulations at this inspection.

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.

The home was not suitably clean and people were at risk from poor hygiene
practices.

The administration of people's medicines was not in line with best practice.

There were not enough staff to meet people's needs promptly.

Staff understood their role in safeguarding adults.

The provider's recruitment procedures were effective in ensuring only suitable staff were employed at the home.

Is the service effective?

Requires Improvement

The service was not effective.

Records relating to people's care and treatment were not fully completed to protect people from the risks of unsafe care.

Staff supervision and training was not up to date.

The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005.

DoLS applications had been made for those people that required them.

Staff demonstrated good knowledge of the Mental Capacity Act 2005.

People were provided with nutritious food and sufficient drinks.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed occasions where people's care and dignity were compromised as a result of the provider failing to ensure that the premises were fit for purpose.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

Care plans were not personalised and did not contain unique individual information and references to people's daily lives.

Risk assessments did not always reflect actions required to reduce risks to people.

Sufficient action had not been taken to ensure people's care records were fully completed.

People were supported to use healthcare services.

There were systems in place to respond to complaints.

People's independence was promoted through activities and community involvement.

Is the service well-led?

Inadequate 

The service was not well led.

The systems in place for monitoring quality and safety were not effective in ensuring that the risks to people were identified and managed.

The provider had failed to act on feedback from people and staff regarding suggested areas for service improvement.

Statutory notifications had been made to the Commission for notifiable incidents.

Greenhill House - Care Home with Nursing Physical Disabilities

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 9 and 10 December 2015. This was an unannounced inspection, and was carried out by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

Prior to the inspection, we viewed all information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

As part of our inspection, we spoke to four people who used the service, two visiting friends or family, the registered manager and 12 members of staff including the care staff and nurses. We tracked the care and support provided to people and reviewed six support plans relating to this. We also looked at records relating to the management of the home, such as the staffing rota, policies, recruitment and training records, meeting minutes and audit reports. We also made observations of the care that people received.

Inadequate

Is the service safe?

Our findings

The Department of Health (DH) publishes the Health and Social Care Act 2008 Code of Practice On The Prevention And Control Of Infections And Related Guidance ("the Code"). The Code sets out the basic steps that are required to ensure the essential criteria for compliance with the cleanliness and infection control requirements under the Health and Social Care Act 2008 and its associated regulations are being met.

The provider had not followed the DH code of practice on the prevention and control of infections. People were not protected from the risk of infection, because the service was not clean and hygienic and there were no checks in place to monitor how clean the environment was.

In several areas of the building, walls were scuffed and floors were not clean. There was dust and debris in the corners of the communal lounge/dining room. We saw some of the casing around pipes and floor lining had come away from the wall, which meant the area could not be thoroughly cleaned. Windows around the home had dead insects along the sills. Some bedrooms had shelves with ornaments and the shelves that we saw were dusty. People's bedroom doors were badly scuffed and the wood was broken in places. Staff said this was damage from wheelchairs; the damage meant it was not possible for these doors to be cleaned to a satisfactory standard.

Although the kitchen looked visibly clean, there was food and debris in the bottom of one of the food trolleys. The slow cookers were dirty with food splashes on the sides. In the food store room there was food on the floor, loose rice grains on the shelf, and there was old food and debris in the bottom of the fridges. The window in the food store room was dusty and dirty and had cobwebs over it and there was dust and debris on the windowsill. The area behind the bread freezer was also dusty and dirty.

The laundry room was dirty and dusty and there were cobwebs on the ceiling. The plaster had come off some of the walls by one of the windows, window frames were split, and clean clothes were being stored in a box on the floor adjacent to the wall. The box was overfilled so clean clothes were in contact with dusty walls. The wall tiles by the sink were dirty and there was a dusty feather duster hanging over the sink. There were bags of soiled linen on the floor waiting to be washed. In order to segregate dirty and clean laundry there was a process for dirty linen to go into the laundry room through one door, and clean linen to go out through another. However the storage of dirty and clean linen in close proximity within the laundry rooms did not reduce the risk of cross contamination.

Laundry cleaning fluids, some of which contained peroxide were not stored safely. They were not locked away, but were stored beneath a shelf on the dusty floor. A wooden shelf was placed on its side to "cover" the cleaning fluids. The door to the laundry was not locked when not in use. This meant there was a risk that people could access the peroxide liquids.

Although there were cleaning rotas in place, these were not being fully completed. For example, in the laundry room, according to the cleaning schedule, internal and external washing machine doors had not been cleaned since 04/11/2015, and low level dusting had not been completed since 03/11/2015. In the

kitchen, the daily cleaning schedule showed gaps which indicated that some cleaning tasks had not taken place on 07/12/2015 and 08/12/2015. A member of kitchen staff said "When we can fit it in we do the cleaning. The weekend staff try and do a bit". All of the cleaning issues we saw were shown to the Head of Hotel Services during the inspection. The Head of Hotel services told us; "The last kitchen deep clean took place at the beginning of 2015" and that there were 70 cleaning hours vacant at the time of the inspection and a recruitment drive was underway. The housekeeping rota showed that no cleaning staff were on duty on Sundays.

The premises were not always managed to keep people safe. Although risks were identified, they were not always acted on in a timely manner. For example, in one person's plan, staff had documented there was a risk of trips and falls due to "ripped vinyl flooring caused by inability to move the bed effectively". This had been written into the plan on 23/05/2015. Although the ripped section of vinyl had been removed, it had not been replaced, and there was still a section of flooring missing in the person's bedroom which meant there was still a risk of trips and falls as the flooring was uneven. It also meant the person's personal environment was not particularly homely.

Due to a lack of storage space throughout the building, some of the corridors were being used as storage space for wheelchairs. Outside of the lifts on the ground floor, several wheelchairs were on charge. Staff said the lifts were used by people, which meant there was a risk that people would not be able to manoeuvre their wheelchairs in the cluttered space. In the entrance to the nursing unit, a bariatric bed (a bed larger than a single size bed) was being stored. This took up a significant amount of space. Staff said they were waiting for the bed to be stored elsewhere but didn't know when this would happen.

Staff said they did not think the building was clean. One person said "The domestics are really short staffed. One person had a spider's nest in their bedroom window and I had to clean it".

These failings amounted to a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

During the inspection we also looked at the arrangements for the storage, administration and disposal of medicines. Medicines were generally being managed so that people received them safely. Nurses administered medicines to people living in the nursing unit, and support workers administered medicines in the residential unit. Medication administration records (MAR) charts were in place, and these detailed people's preferences in relation to how they wanted to take their medicines as well as the reasons they had been prescribed. There were photographs of people in the charts; however, not all of these had been dated. This meant there was a risk that the photographs were no longer an accurate representation of how people looked. This issue had been highlighted during a provider audit dated October 2015, but had not been rectified.

Medication reviews had taken place and the documentation relating to these were filed with the MAR charts. MAR charts in the residential unit were all signed and up to date. However, there were several missing signatures noted on the MAR charts in the nursing unit. For example, one person had gaps in the MAR chart for two medicines on 21/11/2015 and for one on 17/11/2015. Six other people had gaps in their charts. This meant there was a risk that people had not always received their medicines as prescribed.

There were PRN (as required) protocols in place. In some instances, staff had documented why they had administered the medicine, but this was not consistent across both units. In the nursing unit, staff had written the reasons why PRN medicines had been given to people. This meant that staff could easily monitor if there was a specific reason or time of day when people required extra medicines such as pain relief.

However, in the residential unit, this information was not documented. For example, one person had received pain relief on 30/11/2015, 31/11/205, 01/12/2015, 06/12/2015 and 09/12/2015 but the reason had not been documented on the MAR chart or in the daily record.

There were local agreements in place for the administration of certain medicines for PRN use. The forms stated these should be reviewed annually, and there was nothing documented to indicate this had taken place, despite reviews being due in May 2015.

Generally, medicines were stored safely; however, bottles of liquids stored in the medicine trolleys had not been signed or dated when opened. This is good practice to minimise the risk of people being given liquids that have expired.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

The registered manager told us that staffing levels were assessed and organised in a flexible way to support people to pursue their choices of how they spent their day. Staff numbers were based on the needs of people (dependency) and that more staff could be employed if the dependency need arose. However they also told us that due to a high number of support staff and housekeeping vacancies there were occasions when staff were unable to support people to meet their needs for one to one time their visits into the community. The registered manager said they used regular agency staff six days a week to fill their staffing quota. Staff vacancies had been advertised however interest had been minimal; the registered manager felt this was due to the rural location of the service which made travel to the service on public transport difficult. The registered manager was unable to provide us with any dependency assessment of staffing needs for day or night shifts for the home. We were not assured that the levels of staffing were meeting people's needs.

At night there were four care staff members and one nurse on duty. The accommodation in the home was divided between two separate buildings each on two levels. We asked the registered manager how the number of staff had been calculated taking into account any emergency that may arise during the night and given that most people were not independently mobile. There had been no assessment of staffing needs in a night time emergency.

Staff said there were not enough staff on duty to meet people's needs. They said "Some residents are more vocal than others so their needs will get met but there are other residents who can't or won't speak up and they are the ones that lose out when we're short staffed because residents who complain get their needs met first" and "We're short staffed and sometimes this makes me feel as though our work is becoming more task focused rather than person centred, which isn't a good feeling". "We're being stretched, taking on more specialist care that is more time consuming". One member of staff said "Being short staffed takes its toll on us; people are more dependent now, so we need more staff on duty". Care staff said the home was reliant on agency staff and that it was "difficult" to recruit new support workers. Staff also told us of occasions when there had been less than the required number of staff on night duty due to sudden absence. The on call system had been ineffective in ensuring that there were staff called in to cover the shifts.

People we spoke with told us that the staff were very good but that they did not have much time to spend with them. One person said "They do a great job here but they need more staff, there are never enough staff, sometimes I have to wait to get up for a while because they are busy". Another person told us that if they used their call bell at night they were often waiting a very long time for staff to come because if they were working in the laundry they would not hear the bell. There were no call bell audits completed in order for us to check call bell waiting times.

Visitors told us that there were not enough staff to provide their relatives with the stimulation they needed all of the time.

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

The service had a policy and procedure regarding the safeguarding of people and guidance was available in the office area for staff to follow. Staff told us that they would report any issues of concern to the registered manager. Staff were aware of types and signs of possible abuse and their responsibility to report any concerns to senior staff or the manager. Staff also understood the term whistleblowing. The staff all said they felt confident their concerns would be taken seriously.

There was a robust selection procedure in place. Staff recruitment files showed us that the service operated a safe and effective recruitment system. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

Two visitors said they felt their relative was safe. They said "I trust the staff and I do think [person's name] is safe here".

Requires Improvement

Is the service effective?

Our findings

Accurate, complete and detailed records in respect of each person using the service had not been maintained. There was a distinct difference in care plans on the residential and nursing units. All care plans we looked at were written with the involvement of people using the service.

There were gaps in records where staff should have documented the care they had provided. In one of the plans, staff were required to document every time the person had 'opened their bowels' as they frequently suffered from painful constipation. The last recorded date was ten days previous to the inspection; there was no assessment of this or any other records to establish if the person was suffering from constipation. We raised these issues with staff and were told it was likely that the person had opened their bowels as the person would have complained of constipation otherwise; we were told the staff may not have had time to record it. We also saw that the person required weight checks every two weeks, the records showed the person's weight had been checked twice in 2015; there was no assessment of this. Some sections of this care plan had not been updated or reviewed since July 2014. This meant that for this person the staff were reliant on taking a reactive response to the person's care once their health needs increased rather than proactively assessing and reviewing their records to pre-empt the need for a reactive response.

On the nursing unit although care plans had been regularly reviewed and amended as people's needs changed there were gaps noted in daily records where staff should have documented the care they had provided. In one of the plans, staff had not documented anything throughout the day of 28/11/2015. In another person's plan there were gaps on 05/12/2015 and 06/12/2015 when no details of the support provided during the afternoon had been documented.

We found that missing person profiles which were created to assist the police should a person be 'missing' had not been updated for some people for over five years. Some of these profiles contained emergency contact information for people's relatives who were now deceased or staff who had left the provider's employment. In one profile the photograph of the person to be used to help locate the person had not been updated since 2009. The person's appearance had changed drastically and no longer resembled the photograph.

In the residential unit we found instances where significant information relating to people's health needs was not recorded in care plans. For one person who had a sacral sore there was no information in relation to the management of the sacral sore other than where it was; this information was last updated in December 2014. This meant that staff did not have access to information to ensure that the person's needs were met in relation to their tissue viability.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not consistently supported through an effective training and supervision programme. Staff told us they had completed a variety of training courses relevant to their role, such as manual handling, food

hygiene, infection control however they were unsure when they last attended training. One said they thought it was in 2014, other staff said they had not received any training in the last 12 months. Training records did not demonstrate that staff had received appropriate training. The registered manager showed us the training record system that was in place but was unable to state how accurate or up to date the system was as there were staff listed who did not have the appropriate training. Two of the staff who were on duty during the inspection had training records that showed the last training they received as "miscellaneous". We also noted delays in ensuring that regular refresher training had been undertaken as required by the provider. The registered manager confirmed that there was no easy way to check that relevant training had been undertaken due to the complexities of managing and extracting information from the training record database. The staff had not been provided with training to enable them to carry out the duties they were employed to perform.

Staff said they hadn't received supervisions as often as they should have and the supervision records we looked at supported this. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The expectation of the provider was that each staff member received a quarterly supervision. One member of staff said "I think I've had a couple of supervisions, but I've had loads of more informal discussions with my supervisor". Another said "My supervisions are not up to date, they get started but we get interrupted because we're needed on the floor. But if I had a problem or issue I would raise it". We looked at the supervision records of four members of staff; one member of staff had not received a supervision since October 2014, two other staff had received one supervision each in 2015. The last staff record showed that the member of staff had received two supervisions in 2015. The provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views.

These failings amounted to a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding of the Mental Capacity Act (MCA) 2005 and how it related to consent to care. Completed mental capacity assessments were in place in people's care plans. There were however best interest decisions in people's files that had not been reviewed as required. For example one person had a decision in place for the use of bedrails; this decision required a six month review. We found that the last review had taken place in January 2015. This meant that the person's rights were not being protected because the best interest process had not been followed.

These failings amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had acted in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS): Code of Practice and the Mental Capacity Act 2005 Code of Practice. Providers must at all times act in accordance with these Codes. People's capacity to make decisions had been assessed and appropriate applications had been made.

During meal times we saw that there were a range of preferences and choices made by people in each unit. People were supported to have sufficient to eat and drink. People had access to food and snacks outside of regular meal times, and we observed people being offered drinks throughout the inspection. When people had specialist dietary requirements there were plans in place to support this. For example, in the nursing unit, several people had PEG (Percutaneous endoscopic gastrostomy) tubes in situ, and the plans informed staff of the volume and frequency to be administered alongside other guidance. For example, one plan informed staff "Feed only when sitting up in the chair due to safety risks of the tubing when in bed". Speech

and Language specialist (SALT) advice had been sought when required. In one person's plan there was detailed information regarding the texture of food that should be provided for the person which was as recommended by the SALT team. The information included examples of the food texture, and how long staff should take assisting the person to eat. In the kitchen, there was a list that detailed which people required a soft or pureed diet and the kitchen staff said the care staff informed them when people's needs changed.

Requires Improvement

Is the service caring?

Our findings

We found that although staff demonstrated a caring and respectful attitude towards people they cared for, the provider had not demonstrated respect towards people by ensuring that when there were problems with the premises that they were dealt with effectively and in a timely way. For example, because of an out of action shower room in the nursing unit, people had to be wheeled on a trolley along the corridor in order to get to another shower room. This was not dignified. Staff said "Not having the extra bathroom is frustrating; it's not right having to wheel people along the corridors. It's been out of action for months".

Other people were able to have the privacy they needed and could be as independent as they wanted to be. We observed that some people chose to be in the lounge areas, some went outside, and others stayed in their rooms. Staff knew how to respect people's privacy. We observed staff knocking on people's doors before entering their rooms.

People were observed being treated with kindness and compassion. The staff on duty clearly knew people well, and the atmosphere was calm and friendly. They knew people's preferences in relation to their care and the things they enjoyed doing, as well as knowing smaller details such as which mugs belonged to different people.

People using the service said "The staff are kind and caring" and "They do a wonderful job here". Staff said "We are an amazing team here. Staff will do anything for the people living here" and "The building might not look great, but the care here is great". Visitors said "The staff are all so nice; they really do care about my relative. They're all very patient".

Staff were attentive in their approach when supporting people. During the inspection we overheard staff demonstrating their caring attitude in various ways. For example, we heard one staff member discussing how they were planning to support one person who wanted to attend a church service,. We also heard another member of staff say they were taking somebody shopping, another staff member asked them to remind the person to buy a tie for an occasion they were due to attend.

Requires Improvement

Is the service responsive?

Our findings

Care and treatment was not always planned and delivered in line with people's individual care plans. In the residential unit, in every care plan we looked at we found that reviews had not taken place as planned and that key information relating to people's health, lifestyle and preferences had not been recorded accurately or updated when required. We found that care plans had not been reviewed in line with the provider's procedures every six months; some had not been reviewed for over 18 months.

The quality of person centred information was not consistent within the care plans. On the nursing unit, the plans were person centred and described in detail people's preferences in relation to all aspects of their care. Other specialist support was included within the plans, such as tissue viability and physiotherapy.

On the residential unit care plans did not contain up to date information and references to people's daily lives. This meant there was a risk of people not receiving person centred care, because staff did not have the information available in relation to all of the people they were caring for. This can be significant in an environment with people who have learning and physical disabilities as the information can aid staff to provide care to people who have difficulty in communicating their needs. This is of particular relevance when new staff or agency staff are employed at the service to aid these staff in knowing and understanding people. For example we saw that in one care plan some sections had not been updated since September 2013, in these sections of the care plan there was information about a relative of the person and how they assisted the person with certain significant aspects of their care and daily life. The relative of the person had died over six months previously however the plan had not been updated to reflect this. We also saw that where people required the use of a hoist or other equipment there were no person centred instructions built into the care plan to assist staff. For one person whose care plan was last reviewed in July 2014 there was no information about their goals or activities.

These failings amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about people's care needs. When we spoke with staff they were knowledgeable about people's preferences and routines they preferred. For example, one staff member talked about how they responded to people who had difficulties with verbal communication.

People told us that they were given choices in their daily routines, which helped ensure that their views were listened to, and that they were involved in planning their own care. People said a lack of staff could affect choices they made but they were generally happy with their daily routines.

We found that people's individual bedrooms were well furnished, and people were encouraged to personalise their rooms with photographs and memorabilia. This helped ensure that people's rooms were arranged in accordance with the person's wishes and preferences.

People did commented that communication between staff was sometimes lacking and records of requests

were not always passed on. A relative also commented "more staff would definitely help and communications between staff needs to improve, mum will talk to a carer but when the next carer comes on duty they are not aware mum has said anything". Staff told us that miscommunication was common because of the use of agency staff who did not always pass on information or complete records as expected.

There was a building dedicated to activities with a large team of activities support workers and volunteers. During the inspection, several people were playing Boccia, a precision ball sport. The activities co-coordinator explained that the home played in the league table for the south west and that the team took it very seriously. We watched the team playing together and there was a strong competitive spirit in evidence. There was also access to other activities, including trips out for shopping, the pantomime, meals out and the cinema. Activities provided in-house covered a wide range of interests such as woodwork, gardening, quizzes, fishing and meditation. People had access to group activities and 1:1 sessions. One visitor said "[Person's name] has access to lots of activities. They enjoy doing gardening and arts; they get involved with lots of things". Staff added that to improve activities and social interaction for people it would be beneficial to have more staff, a sensory room, access to more vehicles and a separate lounge area rather than one large one. A new conservatory had just been erected which would provide some extra space for people to use.

One person using the service said they were involved in plans with the registered manager to start a tuck shop and that they were planning to help in the reception area once that area had been refurbished. The same person also said they had been asked by the local beavers group to volunteer with them. This showed that some people were actively involved in the community.

There were systems in place to respond to people's complaints, and we saw that the procedure for making a complaint was on display in the home. We viewed examples of formal complaints that had been addressed by the provider and registered manager, and saw that the concerns had been responded to. People and relatives confirmed they knew how and where to access the complaints procedure.

People were supported to use healthcare services. People had regular health reviews with their GP and other healthcare professionals. When a person required additional regular clinical support this was provided. For example, one person was being seen by a dentist. The guidance from the dentist was in the care plan, at the front of the file containing the daily care sheets and on the wall in the person's room. This ensured staff had access to the information they needed in order to support the person with their dental hygiene needs. There was also evidence of input from the community psychiatric team and GPs in people's records. We saw within everyone's care plan that regular visits or appointments with dentists, opticians and dentists had happened when required.

Inadequate

Is the service well-led?

Our findings

The provider's quality assurance systems and processes did not ensure that they were able to effectively assess and monitor the quality of the service and mitigate the risks relating to the health, safety and welfare of service users.

A number of the shortfalls at this inspection related to matters which had been brought to the provider's attention on previous occasions by the Commission. The provider had failed to act on the risks that had been identified. These related to key aspects of the service, such as safety of the premises and the maintenance of accurate records. At the last inspection, two compliance actions were issued in respect of infection control and checking that care plans were up to date and contained sufficient information for staff to be able to meet people's needs. We found however that neither of these actions had been completed to a satisfactory standard.

The provider's systems had also failed to adequately action other shortfalls found at this inspection. These included concerns the accuracy of the person-centred information, staff training and supervision and medicine administration.

There were some systems in place to monitor quality and safety, however these had not been fully effective in ensuring consistent and good quality care was delivered throughout the service. We looked at an action plan dated November 2015 which had been produced by the senior staff team and which included areas monitored such as health and safety, training and infection control. The audits which fed into the action plan were intended to be completed on a monthly, quarterly or annual basis according to the type of audit. We found that the audits had not been undertaken within the timescales set by the provider and had not identified all of the shortfalls in the service provision so that action could be taken to rectify these. We also saw that where audits had found issues to be rectified, action plans had not been completed and the next audit showed the issue as 'ongoing' with no clear end date for completion.

The provider's quality assurance processes had not ensured that the premises and equipment used by the service were safe for their intended purpose and were used in a safe way. No infection control audit had been completed at all and the last complete infection control risk assessment for the home was undertaken in July 2012 and reviewed in July 2013. The provider's policy on infection control was not up to date and did not reflect the latest Department of Health guidance.

In addition to this the provider did not have a current gas certificate in place for the kitchen cooker canopy which did not comply with legislation. The home had been issued with a condition in November 2014 which gave them six months to comply by adjusting the canopy arrangement. The provider was made aware of this, yet there was no plan in place to rectify the issue and the service continued to use the gas cooker. This meant there was a risk to people using and working in the service that food was being prepared using gas when it was not considered safe to do so. We raised this with a visiting property manager during the inspection who told us they would rectify this straight away.

We were told by the registered manager there was a governance system in operation to monitor medicines however the nurses we spoke with said medicine audits were not undertaken. This conflicted with information provided by the registered manager who showed us a copy of the last audit which had been completed during May 2015. The audit form stated medication audits should be carried out at a minimum of six monthly intervals. This meant the latest audit was one month overdue. The completed audit referred to "weekly checks" in relation to MAR charts, but there was no evidence of these checks having taken place during the past seven months. Missing signatures we noted on MAR charts had not been identified by the provider. None of the other issues we noted had been identified during the provider's audit in May 2015. This meant that the system used was ineffective.

The provider did not have an effective system to monitor the quality of people's care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

The provider had failed to seek and act on feedback from people and staff for the purposes of continually evaluating and improving the home Residents and relatives meetings' were held every six months for people living in the home. These meetings were to provide people and their relatives with an opportunity to discuss their concerns and raise issues. We found however that these meetings were not being undertaken every six months. We looked at the minutes from the last meeting in April 2015 and found that there were ongoing issues such as issues with the call buzzer system. People also told us that they didn't always receive feedback for any requests that they made. We found that actions were not recorded as part of a formal auditable action plan, which meant we were unable to check that all actions had been completed.

Another ongoing issue related to people's laundry being returned to them soiled; there were no plans in place to rectify this issue or monitoring of the ongoing situation. We found that instead there was a separate washing machine located away from the laundry room in the residential unit. This was used by some people who lived in the home. People we spoke with explained that their linen had been returned from the laundry soiled with faeces and therefore they preferred to manage their own laundry. We asked the registered manager about this and were told there had been a number of occasions on which faeces had been found inside of the laundry washing machine and on people's washed linen. We asked how this was being managed to ensure that this did not happen again. The registered manager told us it was an ongoing issue between the night staff who undertook some laundry tasks and the laundry staff. We noted however that in staff meeting minutes dated February 2015 there had been discussion of this issue; the issue had been ongoing for at least eight months with no planned resolution.

A staff survey was undertaken in 2015 and the associated report (July 2015) detailed that staff felt that they had not received adequate training, performance reviews, resources to complete their role or that they had opportunities to progress their careers. There was no plan in place to improve upon these issues; the provider had not taken the opportunity to act on this feedback. We found that the staff feedback correlated with the support they had received.

Staff said they used to attend staff meetings, but these had stopped and that morale was "Up and down". One member of staff said that communication "hasn't been too good lately" and "I tend to find out what's happening through word of mouth". Although staff knew that the refurbishment was underway, they did not know how long it was due to take, or in what order it was going to happen. Another member of staff said the activities building was going to be rebuilt and would be finished "hopefully by this time next year".

Staff told us that the registered manager and provider would listen to their views and that they felt able to raise concerns or issues. However this did not necessarily mean their views would be taken into account. For example, the staff had previously raised issues about the laundry facilities and the night time call buzzer system but these had not been rectified by the provider.

We also asked the senior staff for the call buzzer audits and were told these were not monitored; the provider had failed to fully investigate concerns raised by people and staff in relation to calls not being answered or sounded by the system.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that the registered manager had made appropriate notifications.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not planned in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed in a safe way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service provided to people. The provider had failed to assess, monitor and mitigate the risks relating to people's safety and health. The provider had failed to seek and act on feedback from people and staff for the purposes of continually evaluating and

improving the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff to support people safely. The provider had failed to provide staff with supervision and training.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that the home clean and safe for people.

The enforcement action we took:

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