Moorlands Holdings (N.E.) Limited

Hollyacre Bungalow

Inspection report

Front Street
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Durham
County Durham
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Tel: 01913712020

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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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 19 September 2017. The inspection was unannounced which meant the staff and provider did not know we would be visiting. The service was last inspected in 2015 and received an overall rating of 'Good.'

Hollyacre Bungalow provides care and support for up to ten people with a learning disability. It is located in a residential setting in Sacriston in County Durham. Nursing care is not provided.

The service had a registered manager. 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 the time of inspection the registered manager was on annual leave.

There were not enough staff to meet people's needs. On the day of inspection there were two staff on duty, one male and one female, supporting ten people who used the service. There were five female people who used the service and they would not accept care from the male staff member. Therefore the female staff member had to support all five female people on their own. This included hoisting which should be carried out by two staff members. Therefore the services practices were unsafe. We contacted the provider at the beginning of the inspection to request more staff were put on duty immediately. The provider arranged for a further staff member to come in and added an extra staff member onto the rota going forward. The service employed 11 members of staff and they were working long hours to cover each shift. Following the inspection the provider increased the number of existing staff hours and they were interviewing for more staff in order to address this shortfall.

Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. However, staff records were not all completed.

Not all people who used the service were supported to access activities. We looked at three people's daily notes going back to February 2017. One person went to a day centre once a week, the other two people had only left the service once in seven months. People watched the television all day or listened to music. Due to the lack of staff and the need for staff providing two to one care and support, staff told us they could not

provide people access to meaningful activities.

A large proportion of risks to people arising from their health and support needs and the premises were assessed and plans were in place to minimise them. A number of checks were carried out around the service to ensure that the premises and equipment were safe to use. However, we could not establish that the hoists were safe for use; six people who used the service required hoisting. The service had two hoists which had had a service in May 2017; however, the service on these hoists could not be completed due to some parts being deemed faulty and needing replacement. The person who carried out the service said the parts may be difficult to get as the hoists were old and recommended new hoists were purchased. Nothing had been done about this. We followed this up after inspection and the manager had received quotes for two new hoists and was waiting for the provider to agree to the purchase. We followed this up with the provider due to the hoists being unsafe. Two new hoists were purchased on 27 September 2017.

A gas safety check, which took place in December 2016, was passed but it was recommended the provider purchased a carbon monoxide detector for the boiler room. These had not been purchased until we raised the concern at inspection. The fridge in the kitchen was also broken; it was freezing food and leaking. Therefore the safety of the food stored in the fridge could not be guaranteed. We also raised concerns about this during the inspection. A new fridge and carbon monoxide detectors were purchased after the inspection.

We found people received their medicines as prescribed and they were stored in a safe manner.

We found the care plans were person centred and were reviewed monthly. Good end of life plans were in place.

Audits were taking place, however were not robust enough to highlight the issues we found during our visit.

Staff were not supported by supervision. We were told the manager completed a supervision sheet then left it for the staff member to sign. No conversation took place to support the staff member with their development.

Staff understood safeguarding issues and felt confident in raising any concerns they had, in order to keep people safe.

Staff had received Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) training and demonstrated a basic understanding of the requirements of the Act. The registered manager understood their responsibilities in relation to the DoLS. However, we found no evidence of consent.

We observed lunch and found the dining experience needed improving. The majority of people needed support with eating and some people had to wait until staff finished with one person before they could support the next.

We saw some evidence that staff worked with external professionals to support and maintain people's health.

The interactions between people and staff were kind and respectful. We saw staff were aware of how to respect people's privacy and dignity. People and their relatives spoke highly of the care they received. However, due to a lack of staff, people were not provided with choice, for example, they all had to sit in the same lounge together.

Procedures were not in place to support people to access advocacy services should the need arise.

The provider had a clear complaints policy that was applied when any concerns were raised. The service had received no complaints.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered 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 always safe.

There were not enough staff employed or on duty at the service.

Risks to people were assessed to plan safe care or keep a safe environment. However, due to being short staffed, staff could not follow the risk assessments.

Equipment found to be in need of repair or equipment recommended was not purchased in a timely manner.

The provider followed safe recruitment procedures, however the records were not all completed.

Medicines were managed safely.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported through supervision and appraisals.

Consent was not always sought.

The dining experience needed improving.

The premises were not well maintained in terms of cleanliness and décor.

Staff received training to ensure that they could appropriately support people. However, they were not able to put all the training into practice such as moving and handling.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff treated people with dignity, respect and kindness. However due to being short staffed, staff did not have time to care for people in a person centred way.

The service did not support people to access advocacy services.

Records were in place for end of life care wishes and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not supported to access activities and follow their interests.

Care records were person centred and reflected people's current needs.

There was a basic system in place to manage complaints. No complaints had been received.

Is the service well-led?

Inadequate

The service was not always well-led.

Audits were not robust and the services policies needed updating.

Staff did not feel supported by the manager.

Meetings for staff were not taking place.

Meetings for people who used the service were taking place however, actions were not always followed up.

Hollyacre Bungalow

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 was 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 19 September 2017. The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. At the time of our inspection ten people were using the service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider was asked to complete a provider information return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR in a timely manner.

Two people who used the service could communicate verbally, we were able to talk to them and we observed the care delivered to the eight other people living at the home. We also spoke with two relatives over the telephone. We looked at three care plans, and medicine administration records (MARs). We spoke with five members of staff, including the provider's representative, five care staff and a domestic member of staff. We looked at five staff files, including recruitment, training and supervision records.

We also completed observations around the service.

Requires Improvement

Our findings

We found staffing levels were very low. On arrival at the service we found two members of staff, one male and one female, caring for ten people, five men and five women. The male member of staff was not able to support the females who lived at the service as they had registered their preference to receive care from female members of staff only. Therefore the female member of staff was having to provide all personal care herself to the five females, which included hoisting these people on her own, when transferring their positions. Staff also had to do laundry and cooking. Due to the level of care needed, staff were extremely rushed in their duties. We were concerned for the safety of the people living at the service and contacted the provider. The provider was abroad but the provider's son arranged for another staff member to come on duty for the day of inspection and every day going forward.

During the night staffing levels were set at one waking staff member and one sleep in staff member who would be woken if assistance was required. The service had 11 staff employed in total and they were working extra hours to cover shifts. Following our discussions with and feedback to the provider, they agreed to employ more staff.

Staff we spoke with said, "We are all shattered, we can work from 8am till 10 pm then do a sleepover but we don't get to sleep, so if that is our day off we end up sleeping so cant enjoy it, then we are back at work again. It is exhausting."

One relative we spoke with said, "I'm happy for my family member to be in this home but I think the carers should get more pay for the work they do especially when they have to cover for lack of staff." Another relative said, "Staff work hard, but it's too much responsibility in the ration of carers to the people living at the home."

After the inspection the manager contacted the Care Quality Commission (CQC) to say three existing staff had increased their hours, one new staff member had been employed and were awaiting their DBS and they were interviewing two further candidates. The manager also told us they were putting two waking night staff on duty during the night. We have taken this into consideration however we have noted the lack of staff on the day of inspection and the fact that new staff had not being fully recruited.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

A large proportion of risks to people arising from the premises were assessed and monitored. Fire and general premises risk assessments had been carried out. We saw documentation and certificates which showed that relevant checks had been carried out on gas appliances, manual handling equipment and portable electrical equipment. However, a gas safety check which had been completed and passed in December 2016 had recommended the provider obtained carbon monoxide monitors. No carbon monoxide monitors had been purchased. A service on the two hoists could not be completed in May 2017 due to parts on the hoists being deemed faulty and in need of replacement. However, it stated the parts may be hard to get due to the age of the hoists and it was recommended that new hoists were bought. The provider had not bought new hoists. Therefore, we could not establish that the hoists remained safe for use. The kitchen fridge was also broken; it was leaking and kept freezing the food. Staff raised concerns about using the meat stored in this fridge. The provider failed to act on this which meant the provider had not acted in a timely manner.

We contacted the provider after our inspection to share these findings and concerns. The provider arranged for a new fridge and carbon monoxide monitors to be ordered as soon as practicable. Prior to the inspection, the manager had obtained quotes for two new hoists but was waiting for the money to purchase them. We followed this up after our visit and confirmed with the provider that two new hoists were in place on the 27 September 2017.

There was no evidence that people had come to any harm because of these failings. However, we found the above risks to people's safety existed and they had not been addressed via appropriate governance of the service. They were only addressed after we discussed these issues with the manager and provider.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 namely Good governance.

Risks arising from people's health were assessed and risk assessments were in place to mitigate risks. However, staff were unable to follow the moving and handling risk assessments for the female people who used the service if they were on duty with a male member of staff. For example, where people required two staff members to provide care, only one staff member was providing the care. This meant people were at risk due to unsafe practices being followed by staff.

We have taken into consideration that new equipment was purchased after the inspection. However, the provider needs to revisit the processes they have in place to govern the service, so as to minimise the risk of using unsafe equipment.

Records confirmed that monthly checks were carried out by staff of emergency lighting, fire doors and control of substances hazardous to health (COSHH). Staff also took water temperatures weekly and at the time of bathing or showering. These were within safe limits to prevent the development of legionella bacteria in the water supplies and other incident such as scalding.

The provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event of an emergency, such as loss of heating or loss of hot water. This showed us that contingencies were in place to keep people safe in the event of an emergency.

Personal Emergency Evacuation Plans (PEEPs) were in place documenting evacuation plans for people who may require support to leave the premises in the event of an emergency. However these needed to include more information. For example. one person was registered blind and this was not documented on their PEEP.

We asked people who used the service if they felt safe. People said, "I have no problems with staff looking out for me and keeping me safe from harm. I like [named staff member] she spends time with me and sees I'm doing okay." Another person said, "The carers keep me safe and I've felt safe living here," and "Staff are never far from you and that keeps me safe to know they are near."

We looked at the arrangements for the management of medicines. Systems were in place to ensure that medicines had been ordered, stored and administered appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

We observed a lunchtime medicine round, two staff members completed each medicine round. One staff member completed the round and the other staff member observed to make sure it was done correctly. Medicines were given from the container they were supplied in. People were given the support and time they needed when taking their medicines. People were offered a drink of water and the staff member checked that all medicines were taken.

One person we spoke with said, "I always get my medication on time and staff always remind me in advance when my medication is due."

At the time of inspection no one was prescribed controlled drugs (CDs). CDs are medicines which may be at risk of misuse; however a CD cupboard and CD register were available if anyone was prescribed these drugs.

Medicines which required cool storage were stored appropriately in a fridge. Minimum and maximum temperatures were recorded daily and were mainly between 2 and 8 degrees centigrade. Temperatures for the room where the medicines were stored were recorded daily and were less than 25 degrees centigrade. Fridge and treatment room temperatures are taken to make sure medicines are stored within the recommended temperature ranges so that they remain safe for use.

Medicine stocks were properly recorded when medicines were received into the home and when medicines were carried forward from the previous month. This is necessary so accurate records of medicines are available and care workers can monitor when further medication would need to be ordered. Staff had signed MARs to confirm that they had administered medicines, to people as prescribed.

We looked at the guidance information kept about medicines to be administered 'when required'. There were arrangements for recording some of this information, however further information needed to be recorded. For example, one person was prescribed lorazepam (used to treat anxiety) when required but there was no information on what techniques should be used first before administering the medicine, such as calming techniques. This information helps to ensure people are given their medicines in a safe, consistent and appropriate way.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the manager had completed medication audits every month.

Recruitment procedures were in place to ensure suitable staff were employed. Prospective staff completed an application form in which they set out their experience, skills and employment history and two references were sought. The service requested that a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruitment decisions and prevents unsuitable people from working with children and vulnerable adults. We did see that

staff records were not fully completed. For example, three staff files did not contain a signed contract and two files did not have proof of identity. This was rectified by the manager immediately on their return from annual leave.

Staff understood safeguarding issues and knew the procedures to follow if they had any concerns. There were safeguarding policies in place and staff were familiar with them. One staff member said, "Safeguarding is keeping the clients safe and happy and protecting them from anything that could happen." The Commission received a whistleblowing allegation about the service from staff, who raised concerns about staffing levels and faulty equipment on the day of our inspection.

Accidents and incidents were monitored monthly. Although the registered manager monitored these monthly, at the time of our inspection the numbers of accidents and incidents were too low to find any patterns or themes.

Requires Improvement

Our findings

We found that staff were not adequately supported through supervision and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. One staff member said, "The manager completes the supervision record on their own and just gives it to us to sign. Sometimes it is just left out so the manager is not there when we sign it." Another staff member said, "I just get given a form to read through and sign, the manager is often not there when I am reading it, so I can't discuss it."

We discussed this with the manager on their return. They recognised the need to complete supervision and appraisals with the staff member but due to having no administrator and having to carry out care duties, they had no time to complete them correctly. The manager said, "I myself need to do some supervision in more depth. I have never left any for staff to sign. When I have been busy I have given them to staff to read and sign in my company. From now on I will put times and dates for each staff to have their supervisions and appraisals. "The manager said they would rectify this immediately. We asked the provider to send evidence of support and supervision for the manager on the 21 September 2017 but to date nothing has been received.

We looked at what training staff had received and found that staff were suitably trained. Training included fire safety, infection control, safeguarding, moving and handling and dementia awareness. One staff member said, "That is one good thing this company does and that's to provide training, however, the training we received on things like manual handling we can't put into practice due to be having no staff."

These findings evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

We looked at what training staff had received and found that staff were suitably trained. Training included fire safety, infection control, safeguarding, moving and handling and dementia awareness. One staff member said, "That is one good thing this company does and that's to provide training, however, the training we received on things like manual handling we cant put into practice due to be having no staff." Another staff member said, "We do a lot of training, we have just done medicines and Mental Capacity Act." One person who used the service said, "I feel the staff have the right experience to look after me because they get in-house training as well as go on courses, for personal hygiene, because I like to be kept clean."

New staff undertook a 12 week induction programme, covering the service's policy and procedures and

using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. We were told that all new starters completed the care certificate. Each new staff member shadowed a more experienced staff member for two weeks or more if needed. One staff member said, "My induction was good, I felt supported."

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.

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).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We checked whether the service was working within the principles of the MCA and applying the DoLS appropriately.

The registered manager and staff had an understanding of the MCA and the DoLS application process. At the time of our inspection two people were subject to a DoLS authorisation. The manager was waiting for the paperwork to be returned from the local authority for eight people.

However, we found no recorded evidence of consent being sought or best interest decisions being made for the use of bed rails and lap belts. We saw records to show where one person required their medicines covertly (hidden in food), this decision was made in their best interests and the doctor and social worker were aware. However this was not recorded officially, there was no record of a best interest meeting taking place. We discussed with the manager that records needed to be improved in respect of consent to care and treatment, and decision making and mental capacity assessments.

We spent time with people during lunch to sample the dining experience.

One person we spoke with said, "Staff take a lot of pride when making sure I get the food I like. For example I don't like salad because it gives me heart burn, but carers know this and serve me up with corned beef." and "I have a choice of drinks, coffee, tea, orange juice, I prefer coffee and carers give me this most of the time." Another person said, "My carer is good, she monitors my eating to make sure I don't choke. She gives me a choice of food menus, I like chicken curry and slimming world chips."

One relative said, "My family member loves his food, it's his highlight of the day. The carers respond very well to his big appetite and he eats a large portion of food." and "He cannot communicate, but he gets so excited as soon as he can smell the food coming his way."

The overall dining experience was not an enjoyable one for some people. People had to wait for their meals due to lack of staff. The care staff did try their hardest and made sure everyone was settled before serving lunch. However, the majority of people required support with eating and this could not be provided in a

timely manner due to staffing levels. We heard care staff constantly check on people and asking if they were alright or for the person to tell them when they have had enough whilst supporting them. We also heard staff reminding people who could support themselves not to put too much in their mouth. We did not notice people getting desserts. Due to staff being busy people had to wait at the table unattended for at least ten minutes before they were supported back to the lounge.

One staff member said, "We always do a big Sunday dinner and a buffet tea of sandwiches cake and jelly. But the rest of the week it is just basic such as ham egg and chips." Many people required their food to be pureed and we saw evidence of this. However, all the food was pureed together, such as meat, potatoes and vegetables all in one bowl. One staff member said, "We really don't have time to puree each thing separately, we do try on a Sunday so they can taste each different flavour."

We found the premises required updating. One person who used the service said, "The home is not clean enough, the carpet in the lounge is filthy." A relative we spoke with said, "I think the premises are reasonably clean but the exterior needs a serious face lift." and "Ramps are terrible and when I took my family member out for a breath of fresh air the wheelchair wheel got stuck in a hole like a ditch and was a real job getting it freed." We asked the manager if they had a renovation plan, the manager said, "The lounge and dining room have been decorated within a year, new lounge carpets were purchased and new dining tables and chairs were purchased and new blinds in lounge, dining room and conservatory." This meant a deep clean was needed if people were complaining about carpets that were relatively new. We also saw some taps were difficult to turn off and trickled water constantly.

People's rooms were tastefully decorated to how the person wanted them. One relative said, "I particularly like the bedrooms with the sensory lightings."

People were supported to access external professionals to maintain and promote their health. Care plans contained evidence of referrals to professionals such as GPs, the dentists and dieticians.

Requires Improvement

Our findings

On the day of our inspection we found staff to be very caring and support people as best they could. However, the provider did not facilitate a caring service because they did not support staff to care for people in the correct manner due to poor staffing levels and inadequate governance of the service.

We asked people if they thought the staff were caring. One person said, "Staff are very caring, but I would like staff to sit down and spend more time with me and have a chat, but this is not possible as they will have to delegate time away from other people. If they do give me any attention they are always looking out for others over their shoulder." Another person said, "The carer's are good. They respond quickly when you pull the chord for attention."

Relatives we spoke with said, "The carers we have at the moment do a great job, We badly need more staff. I feel the staff are multitasking too much with also doing all the cleaning chores and this is taking their attention away from the caring duties."

Staff we spoke with said, "We do our best and it is rewarding looking after the residents. I enjoy working here but we are asked to do too much." Another staff member said, "We are only still here for the residents, we love all the residents and try our hardest for them."

We observed staff treating people respectfully and providing privacy when needed. Staff we spoke with said, "We always keep the doors closed when people are in the bath and the curtains closed." One person who used the service said, "I have the chance to be private when I want to, I like to spend time in my bedroom playing my CDs, but staff always closely monitor me to make sure I am okay ."

Each person had different needs which staff needed to observe. For example, one person loved to sew but could eat the cotton, staff had to observe this person at all times when sewing. Another person would pick at their skin and another person would hit their head off the wall. These people all needed constant supervision; due to lack of staff, staff explained how they found it extremely difficult to provide person centred care as well as maintaining each person's safety. The only way staff could do this was to keep everybody in one room together. Staff acknowledged that this did not promote people's freedom of choice or respond to their equality and diversity.

People's independence was promoted as best as staff could. One staff member said, "We always prompt people to support themselves as best as they can. [Person's name] takes their dishes into the kitchen and

their washing into the laundry." However one staff member said, "We normally start to get people to bed after tea, this is not their choice but the fact that after 10pm there is only one member of staff on duty. It takes us over an hour to get everyone to bed."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled Person-centred Care.

We did not see any procedures in place to support people to access advocacy services should the need arise. At the time of inspection no one had access to an advocate. Advocacy services help vulnerable people access information and services and be involved in decisions about their lives.

We saw evidence of end of life care plans. These detailed peoples wishes for this time, such as who they would like to be there, what hymns they would like and flowers if they wanted them.

Requires Improvement

Our findings

We looked in detail at the care plans for three people who used the service. Care plans were reviewed monthly. The care plans were person centred and provided detailed information about the care needs and preferences of the person.

The care plans did contain details of the person's life history such as family life and significant events in their life. This supported staff with topics that would encourage better communication and an understanding of the person.

The service used a tool called the DisDAT tool (Disability Distress Assessment Tool). This tool helps identify distress cues for people who have severely limited communication. We saw detailed plans recorded how the person may look if they were content or if they were distressed. What vocal signs they may make or habits and mannerisms. One staff member said, "I know [Person's name] so well I can see when behaviours will happen."

We looked at the provision of activities provided and found very little taking place. People we spoke with said, "I am desperate to see more staff in order to get out to more places. They [staff] just don't have enough time to take me out and I feel locked in here 24/7." Another person said, "[Staff member's name] is very entertaining and I have a lot of fun with [staff members name]."

Staff we spoke with said, "The residents need to get out more, they are stuck in here doing the same thing every single day. We can't even get some to sit in the conservatory so they get a different view because with only two staff we can't provide two to one care if some people are at one end of the home and some are at the other." Another staff member said, "None of our residents are happy anymore, they just sit and watch television." and "If one person wants to watch a movie they all have to watch a movie. [Person's name] loves doing jigsaws but they have to sit on their own and do it because we can't leave everyone else." The person who loves jigsaws said, "I do jigsaws but we are in desperate need of new sets because they are worn and broken. I really wish there were more things to do, as I mostly spend 24 hours inside this home, I would like to get involved in arts and crafts."

We observed people throughout the day and everyone was sat in front of the television. We read the daily notes for three people going back to February 2017. For one person each daily entry said, '[Name] has relaxed at home with her sewing and watching television. Ate three good meals and drank plenty of fluids.' This same entry was recorded every day since 15 February 2017 except one day on the 1 May 2017 when it

was noted that the person went out for lunch. Another person had gone to South Shields for the day on the 18 July 2017 but all other days since 6 February 2017 they stayed at home, watching television or listening to music. The third person went to a day centre one day a week, but otherwise watched television. This person was registered blind.

The provider did not support people to live enhanced lives, as people's fundamental needs, choices, wishes and goals were not always considered or met.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled Person-centred care.

One record reflected that the manager and two staff members took two people to Haggerston Castle for a week in August 2017. The service had their own mini bus which staff told us never got used, as only three employed staff were able to drive. The manager said, "We try our best with activities but some residents don't want to cooperate, or if they do, it is for two minutes. If a driver was in place we could access multi-sensory cinema day trips and other activities that we have always done in the past."

We received feedback from the provider following our inspection to say more activities had been introduced following the concerns raised at the inspection.

There was a policy in place for managing complaints, which was very basic and contained no information on the timescales for resolving complaints. There was no evidence of any complaints being received about the service. We discussed with the manager that the complaints policy needed to be more detailed.

Inadequate

Our findings

The service had a manager who had been registered with CQC since January 2011.

The manager carried out a number of quality assurance checks designed to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The manager completed audits in medicines, infection control, kitchen and staffing. All audits had a tick to say everything was fine and there were no issues. We found the audits had not picked up the issues we found. For example; staffing levels were low; supervisions and appraisals were not taking place effectively; people did not receive care that was person-centred; they were not supported to access activities; there was a lack of recording around consent to care and treatment; hoists needed repairing; the fridge was broken; and records were missing from staff files. We also found the services polices were basic and needed to be improved.

Audits were not robust enough to assess the quality of the service, and because of this, much needed improvements to the service had not been made as concerns and shortfalls were not being identified by the provider as they should have been. .

Meetings for staff were not taking place. The manager would write out what they wanted to discuss with staff and leave it for them to sign to say they had read it. No meetings took place where staff had a voice to discuss anything. The manager agreed to set these up correctly again.

Staff said they did not feel supported by the manager and found them unapproachable. Comments included, "I think the world of [manager's name] but can't approach them, she will snap at you and bite your head off. I think she is stressed and needs support from above." Another staff member said, "I feel like a hindrance on her." A third staff member commented, "We can't speak out about anything as we are worried we will lose our jobs."

People who used the service said, "I don't really like the manager, she is not so responsive to me." Another person said, "I like the manager but I don't see her as much as I would like to," and "Staff are in too much of a rush and it would be better led with more staff."

One relative we spoke with said, "I don't get the see the manager that often, I would like her to be more visible."

Meetings for people who used the service took place every three months. During the meetings people were asked if they had any concerns or requests. One person requested a trip to Blackpool and another requested more craft materials. The provider could not evidence that either request had been acted upon.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not doing anything reasonable practicable to make sure that people who use the service receive person centred care and treatment that is appropriate and meets their needs and reflects their personal preferences. Reg 9 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective systems and processes to make sure they assessed and monitored the service. Records relating to people and staff were not always well maintained. The provider was not acting in a timely manner when improvements and faulty equipment were highlighted. The provider was not acting in the best interests of the people using the service. Reg 17 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not employing and deploying sufficient numbers of staff to meet peoples'

care needs. The provider was not ensuring staff received appropriate on-going supervision and appraisal to ensure they were competent in their role. Reg 18 (1)