Butts Croft Limited

Butts Croft House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 November 2017 and 7 December 2017. The first day of our visit was unannounced.

Butts Croft House provides care and accommodation for up to 35 people. Whilst the majority of people who live at the home are older people living with dementia, the service also offers care and support to young people living with dementia. The home provides eight temporary beds for people who have come from hospital for further care or assessment before going back to their own home. At the time of our visit there were 24 people living in the home.

We last inspected this home in November 2016 when we rated the service as requiring improvement in safe, effective and well-led. The service had an overall rating of Requires Improvement. At this inspection we found improvements had not been made and the provider was not reaching the requirements of some of the Regulations in the Health and Social Care Act 2008. This is the third time the service has been rated as Requires Improvement.

There had been no registered manager at the service for over 12 months. 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. When there is no registered manager in post, the legal obligations imposed by the Health and Social Care Act 2004 remain with the provider.

The provider had not ensured there was a person with the skills and experience to manage the service at the time of our inspection visit. The manager was on annual leave and the home was being managed by the deputy manager who had been appointed three days prior to our inspection visit. Whilst very supportive of our inspection, the deputy manager had limited knowledge of the systems and processes for managing the home.

There was a lack of proactive management and leadership by the provider, which impacted on the quality of service. Quality assurance systems were either not in place or ineffective and failed to identify areas of concern we found during our inspection visit. At our last inspection, the provider gave us assurance improvements would be made. We found these improvements had not been made, and the poor governance of the home had resulted in new breaches of the regulations because the provider continued to place people at risk.

We could not be assured the provider understood the responsibilities of their registration with us. The provider had failed to notify us of important events at the service or displayed the ratings from their last inspection as required under our registration Regulations.

During our inspection visit we identified physical risks related to the premises, that compromised people's safety, that the provider had either not identified or taken action to minimise. Although people felt very safe living at the home, some potential safeguarding incidents had not been referred to the local authority as required. Safety incidents were not effectively monitored and analysed to prevent further incidents from occurring.

There were enough trained staff to keep people safe, but the provider did not have oversight to ensure staff continued to receive training that was appropriate to their role and responsibilities. The provider had not ensured managers and staff always followed the MCA code of practice to make sure the rights of people who may lack capacity to make particular decisions were protected. However in their everyday interactions, staff gave people choices and respected the decisions they made.

People had enough to eat and drink, were supported to maintain good health and received appropriate and timely healthcare support. People received their medicines as prescribed.

Care plans did not always contain sufficient detail to ensure people's care needs were met in a person centred way. However, people were very happy living at the home. There were some very relaxed and friendly interactions between people and staff and warm relationships had been established. Staff knew people well and were generally responsive to their individual needs. Staff promoted people's privacy and dignity and supported them to maintain relationships with those who were important to them.

People were supported to maintain interests and hobbies that were meaningful to them, although some people needed more stimulation and social engagement. Improvements were required to ensure people's preferences for their care at the end of their life were fulfilled.

People were very complimentary about the managers and staff who were committed to providing responsive support in a caring environment. People felt staff and managers were approachable and they were happy to share any concerns with them.

We identified six breaches of the Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People had been subject to unsafe care and support, because risks related to the premises had not been recognised and mitigated to support people in a safe environment. Incidents that affected the health, safety and welfare of people had not always been investigated to prevent further reoccurrence and ensure improvements were made. Potential safeguarding incidents had not always been managed and reported in accordance with the provider's legal responsibilities. There were enough staff to keep people safe. Overall, staff ensured people received their medicines as prescribed and the environment was clean and tidy.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had not ensured managers and staff complied with the requirements of the Mental Capacity Act 2005. However, in their daily interactions staff offered people choice and respected the decisions they made. People were supported to eat and drink enough to maintain their health and referred to other healthcare professionals when a need was identified. The provider had not always ensured staff had received training appropriate to their role and responsibilities.

Is the service caring?

Requires Improvement

The service was caring.

People described the caring attitude of staff in very positive terms and warm relationships had been established. Staff gave people reassurance at times of anxiety or distress and took time to check that people heard and understood what they were saying. People were given choices about their day to day care and their privacy and dignity was supported and respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always contain enough detail to ensure people received person-centred support. Improvements were required to ensure all people received encouragement to engage in activities and hobbies that were meaningful to them. People felt confident to raise any concerns directly with managers and staff.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not ensured there was a person with the skills and experience to manage the service at the time of our inspection visit. The provider's systems to monitor the quality and safety of care people received were not effective. The poor governance of the home had resulted in new breaches of the regulations because the provider continued to place people at risk. Despite the lack of oversight by the provider, managers and staff ensured people received compassionate care and support that had a beneficial impact on their health and well-being.

Butts Croft House

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 checked 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 visit took place on 28 November 2017 and was conducted by two inspectors and an 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 service. It was a comprehensive, unannounced inspection. On 7 December 2017 we contacted the service to inform them that one inspector would be returning that day to follow up on some of the urgent issues identified during our first visit. Inspection visit activity started on 28 November 2017 and ended on 7 December 2017.

Butts Croft is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Prior to our inspection visit, we reviewed information received about the service, for example the statutory notifications the provider had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. We also contacted the local authority commissioners to find out their views of the service provided. These are people who contract care and support services paid for by the local authority. They did not share any information of concern about the service.

During the inspection visit we spoke with 13 people who lived at the home and four relatives/visitors. We spoke with the deputy manager, three care staff, two cooks, a member of domestic staff and a visiting healthcare professional. Healthcare professionals are people who have expertise in particular areas of health, such as nurses or consultant doctors. During our inspection visit we also had a short telephone conversation with the manager.

Many of the people who lived at the home were happy to talk with us about their daily lives, but some were not able to tell us in detail about their support plans, this was because of their complex needs. However, we

observed how care and support were delivered in the communal areas and reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We looked at other records related to people's care and how the service operated, including medicine records, the provider's quality assurance audits and three staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in November 2016, we found the provider needed to make improvements to ensure they were consistently providing safe care and a safe environment for people. At this inspection we found those improvements had not been made, and there were breaches of the Health and Safety regulations. The rating remains Requires Improvement.

Staff completed training in safeguarding people and understood what abuse was and how to keep people safe. One staff member told us what they would do if they saw abuse or poor practice. "I would make sure the person didn't get harmed, stop it and take them somewhere safe." They explained, "I would definitely report it, 100%, to the safeguarding team in the local authority."

The deputy manager confirmed any allegations of abuse would be reported immediately to the local authority and to CQC. However, during our visit we looked at accident and incident reports and identified occasions when people had been involved in altercations with others which had not been reported to the local authority or to CQC as potential safeguarding incidents. For example, on 10 March 2017 one person 'grabbed another person's arm aggressively' which caused them pain. On 29 June 2017 there was an incident when one person acted inappropriately with another person which placed them both at risk. On 17 July 2017 there was an incident between two people which resulted in one person sustaining a 'big bruise' to their right wrist. None of these incidents had been reported as safeguarding issues and a lack of detailed records meant we could not be sure what action had been taken to safeguard people. It is important such incidents are reported to keep people and others safe when they demonstrate behaviours that can cause distress or injury to themselves or others.

During our inspection visit we were made aware of a safeguarding referral that had been made about the home by the ambulance service. The provider had not notified us which is their legal responsibility.

We found this was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We identified physical risks related to the premises, that compromised people's safety, that the provider had either not identified or taken action to minimise. At our last inspection in November 2016 we identified that a patio door leading onto a large first floor balcony was not secure because the lock had been removed. The provider immediately instructed the maintenance person to ensure the patio door was made safe and told us they would arrange for restrictors to be fitted. At this visit we found the lock had not been replaced and although restrictors had been fitted, staff had not secured the door and checked it remained safe. We removed the chain across the top and the doors opened because the door restrictor had not been locked. We checked the maintenance book back dated to July 2017 as the previous book had gone missing. On 13 November 2016 the book recorded 22 window restrictors were fitted, but no locks to the patio doors. This meant the risk of someone falling from the balcony still remained.

One person who lived on the first floor had a fire exit in their bedroom which led onto a steep and narrow

external fire exit stairwell. This stairwell led down to the garden area, next to open land at the side of the premises. The mechanism on the fire door was not working correctly which meant it could be opened with the lightest touch, and potentially from the outside. Fire doors when opened should trigger an alarm, however no alarm was triggered to alert staff that we had accessed the fire exit. Later in the day, staff secured this door but agreed to get it checked to ensure it remained effective and safe. We also found that the call alarm in the person's room was faulty so they were unable to call for assistance in the event of an emergency. This had not been identified by the provider or staff. The deputy manager said, "We have no records to say it needed replacing so if it's not documented, it didn't happen."

Two doors had notices on them indicating they should be kept locked to ensure people's safety. On one door the locking device was faulty which meant it could not be locked securely and safely. The door led to the machinery operating the lift which used a high voltage of electricity. The deputy manager was not aware that the lock was faulty. The other door led to the boiler room and the laundry and staff had failed to lock it. The laundry contained liquids and products that could have caused serious injury to people.

The deputy manager took immediate action to make sure all these issues were immediately addressed. Locks were replaced and an external company checked the safety and effectiveness of the fire exit. However, all the issues we identified demonstrated the provider's system to report, manage and mitigate risks related to the premises was not effective.

This was a breach of Regulation 12(2)(d). Safe care and treatment. People had been subject to unsafe care and support, because risks related to the premises had not been recognised and mitigated to support people in a safe environment.

Safety incidents were not being effectively monitored and analysed by the provider to prevent further incidents from occurring. An accurate incident log was not maintained, despite the provider agreeing to implement one at our previous inspection. For example, we were told of one person who had recently fallen and sustained a fracture to their shoulder. The deputy manager was unable to locate a report for this incident. Another person told us they had fallen out of bed and sustained an injury to their head which had required hospital treatment. There was no accident report or investigation as to the circumstances surrounding the person's injury. One person had fallen on the 6 August 2017 sustaining a deep cut which required treatment in hospital. Although there was an accident report, there were no recommendations as to what actions staff should take to keep this person safe. The same person had an unwitnessed fall three days later on 9 August 2017 which resulted in a cut to their ankle which required further emergency treatment. As a result of a lack of accurate recording, effective action could not be taken to prevent further incidents of harm to people's health, safety and wellbeing. Incidents could not be effectively monitored to identify themes and trends. Effective systems were not in place to respond to safety concerns at the home.

Staff recorded when people had sustained bruises or injuries on body maps. For example, one person's body map dated 30 July 2017 recorded bruising on the underside of their left arm and around their waist. However, there were no records to show what action had been taken to investigate and identify any potential cause of the bruising so appropriate action could be taken.

This was a breach of Regulation 12(2)(b). Safe care and treatment. Incidents that affected the health, safety and welfare of people had not always been investigated to prevent further reoccurrence and ensure improvements were made.

Overall, individual risks to people's health were assessed and plans put in place to manage any identified risks. For example, one person was at risk of skin damage and had a pressure relieving mattress on their bed.

Their mattress was set at the correct pressure for their current weight. This person also had to have their foot rested on a padded foot cushion when out of bed. Their foot was rested on a foot cushion throughout our inspection visits. When a person had lost weight and was at risk of not eating and drinking enough, they were placed on food and fluid charts, weighed more regularly and referred to their GP. The person's weight had subsequently increased. This demonstrated staff took appropriate action when an increase in risk was identified.

However, we identified one person's risk assessments had not been completed despite moving to Butts Croft three months prior to our inspection visit. For example, the person needed support to mobilise. However, there was no assessment or plan to inform staff what equipment to use to achieve this safely and in the least restrictive way possible. Despite a lack of records, staff we spoke with understood the risks to this person and how to support them safely. The deputy manager assured us they would take immediate action to review this person's care needs and risk management plans.

People said they felt safe living at Butts Croft and never had any concerns when being supported by care staff. One person told us they felt safe because, "The gates are locked with a security code." Another person said, "I certainly feel safe here, we always have someone around." Two other people said they felt safe because staff made sure they had the equipment to hand to help them mobilise safely, "Of course I feel safe. There is nothing to worry about and I have my walking frame."

One relative told us they felt reassured because their family member felt safe in the home. They explained, "What [person] likes is that at night they go and check on her which makes her feel really safe."

Some people we spoke with had a clear idea of what to do in the event of an emergency. Comments included: "When the alarm goes off we go to the assembly point" and, "We have a fire drill often so we know that when the alarm goes off we assemble at the assembly point and wait for roll call." However, we were concerned about those people who lacked understanding or who had limited mobility. The provider had a system of recording people's personal evacuation plans (PEEP) in the event of an emergency. However, we found PEEPs were kept for people who had passed away or no longer lived at the home, and new people to the home did not have a PEEPs in place. This meant the provider's system to notify emergency services and to keep people safe was not effective because it did not accurately reflect the needs of those people living in the home.

People and relatives told us there were enough staff to keep them safe. Comments included; "There is a bell, carers respond as soon as they are able to", "Yes I think there are enough staff" and, "Although there are enough staff, sometimes they are busy with other residents." One staff member said staffing levels met people's needs. They said, "You could always do with more, but apart from sickness, we are fine."

The provider was not able to demonstrate they consistently followed safe recruitment procedures to ensure staff were suitable for their roles. In one file there was no evidence of any Disclosure and Barring Service checks. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions. In another file the address on the proof of identification did not match the address on the person's application form. There was no evidence to confirm the provider had identified this or completed a risk assessment. Following our visit, the manager was able to provide confirmation that the DBS had been checked, but this had not been completed until two months after the member of staff started working in the home.

Medicines were stored and kept safely and in accordance with manufacturer's instructions to ensure they remained effective. There was a system to ensure people received time critical medicines as prescribed.

Medicines that required extra checks because of the potential for abuse, were managed safely and in accordance with the legislation.

Records demonstrated people received their medicines as prescribed. However, we identified that some improvements were required to ensure staff always followed best practice when managing medicines. For example, handwritten amendments to medicines administration records (MARs) were not always signed by the person making them or by a second member of staff to confirm their accuracy. One person did not have a photograph on the front of their MAR to reduce the risk of their medicine being given to the wrong person. Where people received their medicine for pain relief via a patch applied directly to their skin, there was no patch application record completed to ensure it was applied to different areas of the body to prevent skin irritation.

The service had received an 'advice visit' from their dispensing pharmacy a week prior to our inspection visit. No major issues were identified, although the pharmacist recommended that training in medicines management needed to be tested and reinforced to ensure staff consistently adhered to NICE guidelines. This advice reflected what we found during our inspection visit.

The home was clean and tidy and there were no odours in any areas of the home. People raised no concerns about the cleanliness of the home with one person describing their bedroom as 'spotless'. We spoke with a member of domestic staff who confirmed they had received training to support their understanding of their role for maintaining cleanliness and hygiene in the home. However, we did observe a couple of occasions when staff did not consistently apply good infection control practices. For example, we saw a number of clean towels and flannels on a bath chair which had been used the morning of our visit. The deputy manager confirmed they should not have been there and arranged for them to be immediately removed from the bathroom. They told us they would remind staff about good infection control practice.

Requires Improvement

Is the service effective?

Our findings

At our last inspection visit we found the effectiveness of the service required improvement to ensure the consistent application of the Mental Capacity Act 2005. At this inspection we found the provider had not ensured the new management team had the understanding to ensure compliance with the legislation. The service remains Requires Improvement.

The Mental Capacity Act 2005 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 are called the Deprivation of Liberty Safeguards.

Managers and staff did not always follow the MCA code of practice to make sure the rights of people who may lack capacity to make particular decisions were protected. Where people were thought to lack capacity to make some decisions, staff had not carried out mental capacity assessments. For example, one person's care plan stated they were unable to make decisions or choices, but there was no capacity assessment to support that statement or indicate exactly what decisions they were unable to make. A DoLS application had been submitted for another person, but there was no record of a capacity assessment to underpin the application.

Another person's care plan stated they had chosen to move to the home because they understood they could not meet their own care needs. This indicated the person had capacity to make their own decisions. However, the care plan also said that a relative had Power of Attorney and managed the person's finances. No capacity assessments had been completed and the deputy manager was unable to confirm whether the Power of Attorney related to health and welfare or finances. The provider had not requested sight of the documents to assure themselves the relative had the legal right to make decisions on the person's behalf.

At the time of our inspection visit the deputy manager was unable to confirm which of the people living at the home had DoLS applications approved and authorised. This was because the provider did not have a DoLS tracker to ensure the management team and staff were aware of people's DoLS status.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not implemented systems to ensure staff acted in accordance with the requirements of the Mental Capacity Act 2005.

However, we saw staff observed the principles of the MCA in their interactions with people. Staff asked people for consent and offered them choices to support them in making decisions. One person confirmed, "They always ask for consent and offer choices generally." Another person told us, "Yes, they respect our preferences."

People's needs were assessed before they moved to the home to ensure it was an appropriate placement for them. People told us the care they received was effective because staff understood their needs and had the right attitude and behaviours to provide them with the support they needed, when they needed it. Comments from people included, "They know what's going on with my care" and, "I think they are well trained."

Staff told us they were required to complete regular training so they felt confident in their role. One staff member said their training was, "Annually refreshed and on line. It's good; some of it is in house like moving and handling." They said, "You do learn. I have done dementia training and got to know the different types of dementia." A visiting healthcare professional confirmed that staff were effective at supporting people with behaviours that could be associated with their diagnosis of dementia. They spoke particularly of one person who had refused basic support. They told us staff had managed the situation well and the person was now eating and taking their medicines because staff 'persevered' with the person.

However, the provider did not maintain a central record to ensure staff had completed essential training and that it was refreshed at the required intervals. They did not have oversight of training to ensure staff continued to receive training that was appropriate to their role and responsibilities. At the time of our visit, the deputy manager had responsibility for management of the home, but they had not received the level of training to support them in their role. For example, they told us they had received on-line training in the everyday application of the Mental Capacity Act 2005, but not in the detail to support their managerial role in ensuring the service met legal requirements.

Staff were not always appropriately supervised or given regular feedback about their performance. Staff told us they had received supervision in the past, but not on a regular basis. One staff member commented, "I haven't had a supervision for a while, I can't even remember my last one." However, staff felt they could approach the manager and deputy manager informally with any concerns. The deputy manager acknowledged this was an area that required improvement and told us they were putting plans in place to meet with staff to discuss their performance and developmental needs.

People had enough to eat and drink. People were happy with the quality and choice of food. One person told us, "If you need a drink or some food, all you have to do is ask." People had access to drinks in their rooms. A relative told us their family member was often reluctant to drink but they felt reassured because, "They always bring her drinks." People who were at risk of not eating or drinking enough had their intake monitored on food and fluid charts.

We spoke with the newly appointed cook about meeting people's nutritional needs. They told us when they started in their role there were no planned menus, but these were being gradually introduced. The cook planned to seek input from people and relatives to ensure the new menus reflected people's likes, dislikes and preferences. They were also introducing a spreadsheet so kitchen and care staff could see at a glance people's dietary requirements and how they required their food to be prepared and served.

People were supported to maintain good health and staff ensured they received appropriate and timely healthcare support. People had access to their GP and other healthcare professionals such as the optician, chiropodist and dentist. Appropriate referrals were made to other care professionals if a need was identified such as dieticians and the Speech and Language Therapy Service. A visiting healthcare professional told us staff referred people appropriately and said, "They ask advice all the time which is good because they learn."

The environment of the home was pleasant and well-decorated. People's doors were painted in different colours and there were memory boxes outside so people living with dementia could locate their room more

easily. There were three different seating areas, each with a different atmosphere so people could choose where they wanted to be. For example, some people chose one area so they could watch the television. Another lounge offered an opportunity for more engagement and social activity. Some people told us they particularly enjoyed the large and well-kept gardens, especially during the summer. People commented: "There is a family room and when I have visitors we can also use my room" and, "I love this place. I can look through the window and see the most amazing views."

Requires Improvement

Is the service caring?

Our findings

At this inspection, we found people were as happy living at the home as they had been during our previous inspection, because they felt staff cared about them. However, the provider had not demonstrated the same caring values by ensuring managers and staff had consistent and timely support and guidance when they needed it. The rating is therefore Requires Improvement.

People described the caring attitude of staff in very positive terms. One person told us, "Staff are caring, the way they speak and the way they look at you." Another person told us, "It is very caring, this place is full of smiles and we have laughs." Relatives confirmed, "This place is relaxed" and, "I think staff are good with people, they treat them very well and we have not noticed anything amiss."

We observed some very relaxed and friendly interactions between people and staff and it was clear some warm relationships had been established. One person was laughing and joking with staff and gave them a big hug before telling us, "They (staff) are absolutely brilliant. I am so happy here." Another person pointed to a member of staff and told us, "She is not a carer to me, she is a friend. I could talk to her about anything. She looks after me really well."

One staff member told us what caring meant to them and the qualities they had that ensured they cared for people in a compassionate way. They explained, "I do care because I take pride in what I do and I do the best I can." They said they looked after people and treated them as they would their own family members. They knew people's backgrounds and said when they assisted people, they talked about things the person was interested in. This showed they were interested in the person and valued what they said. This approach was confirmed by people who told us, "Staff take time to treat me as an individual" and, "Staff are interested in me as a person."

Staff gave people reassurance at times of anxiety or distress and took time to check that people heard and understood what they were saying. One person told us, "They will sit with you when you are unhappy." Another person was anxious about their spectacles. A staff member told them not to worry and immediately went to look for them. Another person got a lot of pleasure from having two dolls which they carried around with them. Staff helped the person care for the dolls by assisting them to wrap them in blankets to keep warm.

A visiting healthcare professional particularly commented on the caring atmosphere within the home. They told us, "It is like a home and not an institution because the carers genuinely care. I think the care is exceptional here. I have never heard staff moan or groan. They treat the residents like their own family members."

People told us, and we saw, they were given choices about their day to day care. One person was cold and wanted a blanket. The staff member gave the person a choice of which blanket they wanted. The person chose which one they wanted and then said to the member of staff, "I do love you."

A staff member described how they protected people's privacy and dignity. They said, "If we are in people's rooms we close curtains and doors to protect them. If in communal bathrooms and toilets, we lock the doors." This staff member explained that part of helping to protect people's privacy, involved encouraging people to do as much as possible for themselves when they were assisting them with personal care. They recognised that supporting people's independence was an important aspect of respecting them as individuals. One person clearly valued this independence because they told us, "I wash myself, they don't have to help me." A relative told us, "I have never seen anyone being stopped or discouraged from doing something." However, other people felt happier to be cared for, with one person explaining, "I like it here because staff do every little thing for me. I don't have to think about a thing."

People were supported to maintain friendships and relationships with family. Relatives confirmed that, where appropriate, they were involved in their family member's care planning and were made welcome whenever they visited.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated the responsiveness of the service as good. At this inspection we found improvements were required to ensure people's physical, emotional and social care needs were consistently responded to.

Each person had a care plan but they were not consistently detailed. Some care plans were person-centred and provided information for staff about how to deliver care in the way the person preferred. For example, one person's care plan gave information about what personal care they were able to do for themselves and the clothes they preferred to wear. Another person's care plan lacked information about how staff were to support the person with important aspects of their care, such as their mobility and skin care. When we spoke with staff, they could explain this person's needs and the support they required, such as when moving around the home. However, staff who were not familiar with the person might not deliver effective person-centred care because of the lack of detail in the care plan.

Care plans were evaluated on a monthly basis to ensure they continued to meet people's changing needs. There was also a holistic evaluation by the person's keyworker. A key worker is a member of staff who is allocated to support a person on an individual basis. The care plan which lacked detail had not been evaluated which meant the lack of information had not been identified.

Overall, people told us staff were responsive to their requests for assistance and support, although some people said they had to wait sometimes if staff were busy. Comments included: "If they are busy they take their time" and, "I don't always get what I want when I want."

There was no activities co-ordinator in post. Staff supported people with activities and hobbies as part of their day to day support. On the whole people felt positively about the level of social engagement and activity within the home. One person told us, "Yes we have activities, in the summer we get to go in the garden." Another said, "I am encouraged to pursue my interests, I like to look at books." Another person had been on a short break supported by a member of staff. A relative whose family member chose not to engage in activities told us staff sat with the person to ensure they did not become socially isolated. However, other people felt they would like the opportunity to do more. Comments included: "I can choose what activities I want to do, but there is not much to choose from" and, "They used to have someone coming in for some painting of sorts, but they have stopped and I am not sure why."

Some people in one of the lounges enjoyed participating in activities on a one to one basis with staff. One person was sitting doing a puzzle with a staff member and another enjoyed doing a counter game. Other people chose to sit in another lounge and watch television. However, some people had little to stimulate or occupy them. We asked one member of staff what would happen if there was an additional staff member in the home. They responded, "Activities – we need to do more with them. We do things but there is nothing much to keep them stimulated."

The deputy manager was not aware of the Accessible Information Standard (AIS). The AIS aims to make sure

that people who have a disability, impairment or sensory loss get information that they can understand and any communication support they need. However, we saw staff appropriately supported people who had sensory impairments. For example, staff ensured people with sight problems had their glasses on and that they were clean and checked people's hearing aids to see if they were working properly.

People were supported with end of life care at the home. Some people had 'Respect' forms in place which captured their views regarding resuscitation in the event of a cardiac arrest or death. There was no process to share this information with staff so they knew what action to take in an emergency. On the second day of our visit the deputy manager had introduced a 'butterfly' in each person's memory box who had an advance decision in place. This meant staff could see at a glance what action they needed to take to ensure people's wishes for resuscitation were respected.

We received mixed feedback when we asked people if their wishes for care at the end of their life had been discussed with them. One person told us, "They have asked about end of life plans and I have indicated I prefer cremation." Another person said, "Yes I have been asked about end of life." However, the responses indicated this was more about their wishes for what should happen after death. The deputy manager explained that end of life care plans were put in place when it became clear a person was approaching the end of their life, but this meant the person may not be well enough to make their feelings known. The deputy manager acknowledged they needed to introduce a system to ensure people were supported to make decisions about their preferences for end of life care when they were able to express their wishes.

People and their families all said they felt able to raise any concerns they had with managers and staff. When we asked one relative if they had ever seen a copy of the complaints procedure they responded, "I don't know, but if I had got a complaint I would just go and see [deputy manager] and [manager]." Other comments included: "I have never complained, I can speak to the manager if there is a problem" and, "I have no concerns. If I have any issues, I just speak to the manager." The deputy manager was not aware of any complaints that had been received in the 12 months prior to our inspection visit and none had been formally recorded.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the governance of the home required improvement. This was because the provider did not have consistently effective auditing systems and processes. At this inspection we found no improvements had been made and there were further breaches of the Health and Safety regulations. The rating remains requires improvement.

There had been no registered manager at the service for over 12 months. The previous manager had left in June 2017 before they had completed their registration with us. The provider had promoted the deputy manager as the manager, but they had not started their registration process at the time of our inspection visit. We spoke with them by telephone and they assured us they would complete their application as soon as possible. Until the manager is a registered person, the legal obligations imposed by the Health and Social Care Act 2004 remain with the provider.

This was a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the service was always managed by an appropriate person.

The provider had not ensured there was a person with the skills and experience to manage the service at the time of our inspection visit. The manager was on two weeks annual leave and the provider was abroad for four months. The service was being managed by the deputy manager who had been appointed three days prior to our inspection visit. The deputy manager had worked in the home for a number of years as a team leader, but by their own admission, they did not have any experience of a management role. Whilst they were very supportive of our visit, they had limited knowledge of the systems and processes for managing the home. For example, they were unable to confirm who had an approved DoLS in place.

We found the service was not well led and systems to monitor the quality and safety of care people received were not effective. The provider's own quality assurance systems failed to identify areas of concern we found during our inspection visit that affected the delivery of care. We continued to find that risks to people's health and well-being had not always been assessed appropriately to ensure people were safe.

Speaking with the deputy manager and reviewing the audit systems we identified a lack of proactive management and leadership which impacted on the quality of service. For example, the provider had not completed monitoring and analysis of any accidents or incidents that occurred in the home. This lack of effective and proactive analysis meant appropriate action may not be taken which placed people at risk. Some environmental risks we found such as unlocked doors, faulty coded locks, and emergency fire doors which were not routinely checked, posed a risk to people's safety.

Effective systems to monitor safety checks were not in place. Some fire safety checks were not completed which had potential to place people and staff at risk in the event of an emergency. For example, external fire risk assessments completed in February 2016 gave the provider recommendations to follow to keep people and the premises safe. The provider had signed this risk assessment to say all actions were completed by December 2016. This risk assessment stated all fire doors and escape routes were to be maintained.

However, at this visit we found some fire doors were not operating effectively. Emergency lighting checks and fire alarm checks had not been completed in accordance with the fire risk assessment. We looked at the provider's Emergency Evacuation plan for the service. This was not dated and referred to a previous registered manager and deputy manager who no longer worked at the service. Current management contact details were not included within this document which meant it was difficult to know who to contact in an emergency. The provider' system for notifying emergency services of what assistance people needed to evacuate the home was not fit for purpose because it did not accurately reflect the needs of those living there.

We looked at the processes used to ensure people received safe and effective care, from staff who were trained and qualified to provide that care. There was no central system that monitored training so the provider could ensure staff received essential and refresher training when needed.

The provider's checks had not identified that staff recruitment procedures had not been consistently applied and safeguarding matters had not been referred to the local authority safeguarding team as required.

We asked for examples of other audits the provider completed that gave assurance that people received a service that was safe, effective and responsive to their needs. For example, medicines audit, infection control, water safety checks, health and safety and care plan audits. The deputy manager was unable to provide us with evidence of completed audits, because they could not locate them, or they had not been started. The deputy manager was open that checks and audits needed to be improved. They explained that monitoring systems had not been maintained under the previous manager and said, "We need to get a system in place."

The provider told us at the November 2016 inspection they had increased their visits to the home and spent more time there. They accepted their checks were not formally recorded to provide an audit trail of actions taken to address issues identified during their visits. At this inspection visit, staff told us the provider did not visit on a regular basis. We found no records of the provider's visits and the issues we found during this inspection had not been identified by the provider or manager before they went on leave. At the last inspection, the provider gave us assurance improvements would be made. We found these improvements had not been made and as a result, the poor governance of the home had resulted in new breaches of the regulations because they potentially placed people at risk.

The deputy manager told us there used to be meetings to seek feedback from people and their relatives about their care. However, they were unable to tell us when the last meetings took place or show us any minutes of those meetings. Therefore we could not be assured these meetings occurred on a regular basis to continually seek feedback from people who used the service. We were told no satisfaction questionnaires had been completed since our last visit. This meant we could not be assured that effective systems were in place to gain and use people's feedback to make improvements to the quality of care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective systems were not in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing.

We could not be assured the provider understood the responsibilities of their registration with us. The provider had failed to notify us of at least three incidents of alleged abuse as required under our registration Regulations. They had also failed to notify us at least two incidents when people had sustained serious injuries and when people had applications to deprive them of their liberty approved by the supervisory

authority.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

It is a regulation, which came into force on 1 April 2015, that says providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. When we arrived for our inspection, we saw the provider was not displaying their CQC rating from our previous inspection visit. We had already identified this as an issue at our last inspection visit so the provider was aware of their legal responsibility.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to display their CQC rating of performance.

Despite the lack of oversight by the provider, staff felt optimistic about the future management of the service because they had confidence in the new manager and deputy manager. Comments included: "[Name of manager] has got to learn. She has been thrown in the deep end but she has the care and compassion for people and she has their interests at heart" and, "I think the leadership is good. If [manager] and [deputy manager] stick at it, together they could make something of it. They do work well together."

Staff particularly commented on the resilience and motivation of the deputy manager who took immediate action following the first day of our inspection visit to address our immediate concerns. For example, they had taken action to ensure the safety of the environment, collated all the training staff had received and introduced a system so staff knew what medical interventions people had agreed to if they experienced a cardiac arrest. They had reviewed the filing system and introduced a process to gain feedback about the quality of service from visitors to the home. Comments from staff included: "Everybody has pulled out everything in the last few days because it is a team place. I can't fault [deputy manager] in the last 10 days" and, "Everybody just came together to get your concerns rectified. I do think everybody has made an effort." A visiting healthcare professional commented, "They [deputy manager] are very transparent and very open. They phoned and asked me for advice."

Staff who worked in the home described good team work and were committed to providing responsive care in a friendly and caring environment. This was recognised by people and their relatives who were very complimentary of the managers and staff team. One relative commented during our inspection: "The staff are amazing and don't just see it as a job but treat the residents as friends and show respect and kindness to them all." The provider needed to ensure managers and staff had the support they needed so they could continue to provide the standard of care which had a beneficial impact on people's health and well-being.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Care Quality Commission of incidents that occurred in the home that affected the health, safety and welfare of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005. Mental capacity assessments had not been completed when there were concerns that people were unable to consent to their care and treatment. The provider had not checked that others had the legal right to make decisions on behalf of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not investigated Incidents that affected the health, safety and welfare of people to prevent further reoccurrence and ensure improvements were made. People had been subject to unsafe care and support, because risks related to the premises had not been recognised and mitigated to support people in a safe environment.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not taken appropriate action without delay to safeguard people from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display in their premises their most recent rating by the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The provider had not ensured the service was always managed by an appropriate person.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have systems and processes to monitor the quality of service or ensure they were meeting other requirements within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a warning notice against the provider.