Romney Cottage Residential Care Home

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 August 2016 and was unannounced.

Romney Cottage Residential Care Home provides care and support for up to 22 people. There were 11 people living at the service at the time of our inspection. People cared for were all older people; some of whom were living with Korsakoff syndrome, a chronic memory disorder most commonly caused by alcohol misuse, dementia and some behaviours which may challenge others. People were living with a range of care needs, including diabetes and epilepsy. Some people needed full support with all of their personal care, and some mobility needs. Other people were more independent and needed less support from staff.

Accommodation is arranged over two floors with communal lounges and dining areas. People had their own bedroom, shower and bath facilities were shared. Access to the first floor is gained by stairs, making some areas of the service inaccessible to people with limited mobility.

The service did not have a registered manager in post at the time of our inspection; a registered manager had not in post since February 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a manager to manage the service who had taken up the position in March 2016. They confirmed their application to manage the service had been made and received by the Care Quality Commission (CQC). The new manager was present throughout our inspection. The service was also supported by the recent appointment of a specialist social care consultancy service.

At the last inspection on 25 and 26 January 2016 the service was placed into special measures by CQC. On 17 May 2016 a further focussed inspection looked at the safety of people at the service; this included administration of medicines, how risks were assessed and managed as well as how incidents and accidents were investigated and mitigated. We found not enough improvement had been made. This inspection again found there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve our continued concerns.

Medicines were not always available in the service when people needed them; obsolete and out of date medicines were stored with current medicines and a recent audit identified concerns about medication record keeping.

Restraint was used to provide personal care; staff were untrained in how to do this; staff and the acting manager had not recognised this as a form of abuse.

Aspects of the service were not well maintained or clean; a fire door did not meet requirements, window restrictors were not always in place or used where needed.

Recruitment processes were incomplete; this did not promote and ensure the safety of people at the service.

Training had substantially lapsed; supervision of staff had not taken place to meet the service's policy on this; competency checks, other than in medicines, did not ensure staff had the right skills and knowledge to support people.

Some Mental Capacity Act and Deprivation of Liberty Safeguards had not been correctly understood of applied.

Staff lacked training and knowledge to recognise poor practice; this impacted on the care people received.

People felt activities were the same as they had always done and did not necessarily reflect their interests.

Care planning did not always give staff sufficient guidance about how to safely and consistently support people; some needs assessments were completed incorrectly and it was evident some people's needs were not being met.

Leadership of the service was poor. The provider had not ensured previously notified breaches of regulation were properly addressed.

Notification, required by law, was not always made to the Commission when people had passed away.

Incidents and accidents had reduced and some risk assessments reviewed.

People were happy with the choice and quality of food; they told us staff were friendly, happy and did what they thought they should to support them.

The provider recognised the requirement to improve the service and had enlisted the support of a consultancy service to help them do this. However, this had not brought about any change to the service people received.

The overall rating for this provider remains 'Inadequate'. This means that it has remains in 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Working practice did not ensure people were not safeguarded from abuse.

There were not sufficient numbers of suitably skilled and knowledgeable staff to meet people's needs. Some staff recruitment processes were incomplete.

Medicines were not always administered and managed as should be expected; plans to deal with emergencies were not always complete and aspects of the building were not properly maintained or promote safety.

Risk assessments had been reviewed and accidents and incidents investigated.□

Is the service effective?

Inadequate

The service was not effective.

Training for new and existing staff had lapsed, staff were not trained in or assessed as having some key skills to support people's needs.

Requirements of the Mental Capacity Act and Deprivation of Liberty safeguards were not fully understood or always correctly applied.

Health action plans were in place but staff did not always recognise when people needed support. People were supported to attend appointments.

People told us they enjoyed their meals□□

Is the service caring?

Requires Improvement

The service was not always caring.

Care planning did not reflect the involvement of the people they were intended to support.

Staff interactions were compassionate and well-intended but knowledge levels and a lack of awareness did not always enable staff to recognise poor care.

Staff were mindful of people's communication needs.

Is the service responsive?

Inadequate

The service was not responsive.

Activities were limited and did not meet people's expectations and interests.

Care planning was not sufficiently developed to provide sufficient guidance to staff about how some people needed to be supported.

Some people's needs assessments were not correct; it was evident their needs were not being fully met.

An accessible complaints procedure was in place but people did not wish to raise any concerns.

Is the service well-led?

Inadequate

The service was not well led.

Leadership and management of the service was inadequate. Concerns identified at our last inspection had not been fully addressed; new concerns were identified at this inspection.

Checks and audits had not enabled the provider to meet regulatory requirements.

Notifications were not always made to the Commission when needed.

Romney Cottage Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to check if breached regulations, identified during our inspections of 25 and 26 January 2016 and 17 May 2016, had been met. We looked at the overall quality of the service to provide a new rating for the service under the Care Act 2014; prior to this inspection, the rating for the service was Inadequate.

We undertook this inspection of Romney Cottage Residential Care Home on 30 and 31 August 2016. The inspection was undertaken by two inspectors.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also reviewed action plans and some progress updates sent by the provider following the last inspections.

We met each person and spoke with eight people who lived at the service and observed their care, including the lunchtime meal, some medicines administration and activities. We inspected most areas of the environment and equipment used at the service. We spoke with five of the care staff including a member of the night care staff, the cook and cleaner as well as a visiting health care professional, the acting manager, the provider and a member of the consultancy team appointed by the provider.

We 'pathway tracked' three people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for three

other people.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, some quality audits and policies and procedures. We also asked for and reviewed the development plan of the service following the intervention of a consultancy service appointed by the provider.

Inadequate

Is the service safe?

Our findings

At our last full inspection of the service on 25 and 26 January 2016, we reported on a number of areas where people's safety at Romney Cottage was not ensured. The service was rated as inadequate overall. Our further inspection on 17 May 2016 focused on if sufficient improvement was made to make the service safe; sufficient improvement had not been made and the service remained inadequate in this area.

Our previous inspections identified the service had failed to ensure risk assessments recorded sufficient measures to keep people safe; that they were appropriately reviewed; reflective of people's changing needs and did all that was reasonably possible to mitigate risks. People were also at risk associated with the unsafe management of medicines; insufficient staffing levels and deficiencies within staff recruitment processes.

Following our initial inspection, the provider submitted action plans setting out what they had done and proposed to do to address the breaches identified. The provider told us staff responsible for medication had received further training and audits would be completed weekly; a more comprehensive system was being introduced to support care planning and assessing risks; a proactive approach was being taken in relation to incidents and accidents to highlight areas of risk and ensure lessons were learnt.

At this inspection, some work had been undertaken to addresses some of our previous concerns, however, not enough improvement had been made in all areas and new concerns were identified; people were still not receiving safe care.

People were not protected from the risk of abuse. One person frequently resisted support provided by staff to deliver personal care and the application of creams to protect their skin. Staff told us and incident reports confirmed the person could become physically aggressive, verbally abusive and destructive towards their environment. In order for some staff to feel safe to deliver personal care, they told us it was not unusual for up to four staff to tend to the person at once. This enabled staff to 'hold and restrain' the person while remaining staff delivered personal care. None of the staff involved were trained in restraint practices. Protocols were in not place about the use of restraint, which, for example, are expected to follow national guidance and good practice, including a full description and review of every incident of restraint and appropriate monitoring of recovery afterwards.

Staff had raised concerns about a lack of equipment, such as a standing aid, which may have assisted the person and a referral to the occupational therapist had been made together with a prescription for as and when needed medicine, which may reduce the person's agitation. However, although the acting manager had prepared a support plan acknowledging the person became 'anxious' and pre-emptively 'non-compliant' over personal care and may be unable to communicate pain; behaviour records evidenced the need for multiple staff to support the person and their continued un-acceptance and distress of personal care delivered. The person was not protected from abuse and improper treatment, because staff and the acting manager had not recognised the support provided to this person did not meet with regulations.

The provider had not ensured staff received training relevant to their role and at a suitable level to make sure any control, restraint or restrictive practices are only used when absolutely necessary, in line with national guidance and good practice, and as a last resort. This was a breach of Regulation 13 (4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough suitably skilled or competent staff deployed to safely deliver the support some people needed. Providers are required to ensure there are sufficient numbers of suitably qualified, skilled and competent staff to, at all times, meet the needs of people at the service. Although the provider used a needs assessment tool to determine the numbers of staff needed; due to the lack of evaluation of induction training, on-going training, competency assessment, formal regular supervision and unavailability of certificates for training delivered by former employers, they were unable to meaningfully determine the effectiveness of staff and their consequent ability to safely meet the needs of people at the service. Concerns were identified during this inspection about staff difficulty in dealing with behaviours that challenged, their use of restraint to deliver personal care to one person and, in the absence of any restraint training and protocols, not recognising this amounted to abuse.

People were at risk of receiving poor care which impacted on their safety because there were not sufficient numbers of suitably qualified, skilled and competent staff to meet people's needs. This was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We assessed the procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. A recent audit highlighted a discrepancy in records between the quantity of a medicine held, used and disposed of. The medicine was subject to specific storage and use requirements; the discrepancy necessitated a referral to the Safeguarding Authority and subsequent notification to the police. Although these referrals had been made, it highlighted concerns around the administration, recording and disposal of medicines. Our further review of medicines administered found the application of topical creams was not always recorded, additionally there were some out of date homely remedies (olive oil for ear treatment) and an obsolete prescribed cream stored in the medication trolley. Discussion with staff found a delay recently occurred in the administration of 8am medicines. This was because stocks held in the medication trolley were not replenished in time from stocks locked elsewhere in the service. Medicine administration records did not reflect on that day people had received their medicines approximately two hours later than otherwise administered.

Where needed the service had sourced pressure reducing mattresses and cushions to help safeguard against the development of pressure areas and consequent risk of skin breakdown. Although in use, staff were unclear what the pressure settings should be and unaware who was responsible for checking the settings were correct and air pumps operated as they should. One air pump had a red 'low pressure alarm' light lit. The acting manager was unable to provide any explanation why the light was on or any reassurance the pump was operating correctly and inflating the mattress to the required pressure. The service did not have any reference material or instructions about the pump. A lack of accountability and understanding about correct operation meant people were at risk from the equipment not operating correctly or being used as intended.

Some people may need help and assistance to leave the service in the event of an emergency evacuation. Individual personal emergency evacuation plans (PEEPs) to establish people's needs during these circumstances were not in place for each person. Discussion with the acting manager found they had prioritised and completed PEEPs for people with higher support needs, but had not completed any plans for the remaining people. Deficiencies in PEEPs availability had been pointed out during the last inspection. Additionally, the acting manager was unable to provide details or records of when fire drills had taken place.

Staff were therefore not aware how all people may respond to a fire alarm, the support they need to leave the service safely or practiced in evacuation procedures. This placed people at risk.

We looked at most areas of the service, providers are required to ensure the premises and any equipment used there are safe. A fire door had a hole in it where a lock had been removed and a fire door to the archive room was propped open and could not automatically close as it was designed to do so. Window restrictors, designed to limit opening to safeguard against falls and any unsanctioned entry or exit of the service, were not operable. We pointed out to the acting manager, when tested during the inspection, a ground floor window in an unlocked and unoccupied bedroom was not restricted in opening and was not capable of being re-closed. The window remained open overnight until pointed out again to the acting manager the following day when it was secured. Window restrictors were not limiting window opening in the second floor bathroom, the acting manager's office or adjoining archive room. Despite assurances these rooms were locked when unoccupied, they were found unlocked and unoccupied on multiple occasions during the inspection. This presented an opportunity for unsupervised access and therefore a potential falling hazard. The electrical installation test certificate for the service had expired; it was not possible to know whether the electrical wiring complied with current safety requirements. Kitchen records showed one of the refrigerators regularly operated outside of required temperatures; we found food placed in the oven to slowly cool, rather than rapid cooling and suitable refrigeration which greatly reduce the risk of harmful bacteria developing. Risks around the storage of food had not been properly addressed.

Delay in the administration of medicines and deficiencies in its recording and disposal did not promote the proper and safe management of medicines. A defective fire door; unrestricted window opening; a lack of emergency evacuation plans for each person and unaddressed food storage concerns did not all that was reasonably practicable to mitigate risks. This placed people at risk. This was a continued breach of Regulation 12 (1)(2)(a)(b)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All premises and equipment used by the service must be clean and properly maintained. Inspection of the kitchen found the vinyl floor covering was not clean; there was a visible ring of dirt on the floor around the legs of kitchen units and crumbs beneath the unit; a plastic crockery drainer in the sink was encrusted in lime scale. The kitchen floor covering was damaged and, although authorised by the provider for replacement, it was not clear when this would happen. Checks of bedrooms found staining on a wall next to a headboard and some dirty, fabric covered headboards in other bedrooms. The carpet in the first lounge from the main entrance was dirty and stained. There was little structure in relation to stored equipment, such as mattresses, wheelchairs and lifting aids, some of which was stored in people's bedrooms, unoccupied bedrooms and randomly throughout the service. Discussion with the provider found there was no schedule of planned maintenance for the service.

The service was not clean and properly maintained. This was a continued breach of Regulation 15 (1)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected as far as practicably possible by a safe recruitment system. Photographic proof of identity had not been obtained for some staff. Although Disclosure and Barring Service (DBS) checks were undertaken when staff were recruited, records were not always kept when the results were received, therefore it was not possible determine if some staff began working at the service before DBS checks were received. Appropriate references were not always taken up, for example, where previous employers were known, references were obtained from friends rather than employers as regulations require. Systems in place were incomplete; this did not promote the principles of a robust recruitment process to protect the safety of people living at the service.

This is a continued breach Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's individual risk assessments were reviewed and updated in relation to falls and other known conditions. The service had recently introduced processes to help staff spot signs of people deteriorating, which could lead to earlier interventions, for example, loss of weight linking to underlying conditions and risks of skin breakdown, malnutrition and dehydration. New equipment for testing diabetic blood sugar levels was purchased and in use and newly established audit processes, reduced the risk of future medication recording errors.

Accident and incident report forms had been completed by staff and actions to prevent recurrences documented. For example; when people had falls; appropriate preventative measures had been investigated, put in place and, where needed, referrals made for additional help from health care professionals such as occupational therapists. Evaluation and review of incidents and accidents took place and records showed a reduction in numbers recorded; this was however also in part due to the reduced occupancy of the service and previously high risk people no longer accommodated there.

Fire exits were marked, unobstructed and external fire escapes in good repair; fire alarms were tested weekly and logged and fire extinguishers had routine safety checks. Water quality and temperatures were regularly tested; current certificates were in place for gas safety and portable electrical appliances. Equipment such as hoists had been serviced in line with manufacturers' guidelines, but, although currently certified as fit to use, service engineers recommended their replacement rather than future servicing because of their age.

Inadequate

Is the service effective?

Our findings

Our last full inspection of Romney Cottage on 25 and 26 January 2016 found a number of breached regulations which meant the service was not effective. These were about ineffective induction training for new staff and a failure to follow the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards when restrictions were placed upon people to help keep them safe. These same concerns were also raised with the provider following an earlier inspection on 2 October 2014.

At this inspection, some work had been undertaken and partially addressed one previous concern, however, not enough improvement had been made in all areas and new concerns were identified; the service remained inadequate in this area.

In action plans, the provider gave an undertaking that new staff would be required to complete the new care certificate and supervised until complete over a 12 week duration; and anyone having previously worked in care settings would still be required to complete the care certificate, but not necessarily supervised for the full 12 week duration. The Care Certificate is a set of standards that social care workers should keep to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers.

Training records showed although staff, including the five newest care staff, had started the training towards the care certificate, no course work had been completed by most of these staff and that which had, had not been evaluated. Additionally, no competency checks, other than for medication administration, had taken place to ensure any training provided was embedded into practice or that training acquired in previous care settings met the needs of people at Romney Cottage.

On-going training had substantially lapsed in multiple areas. For example, of the 17 staff employed, including the acting manager, none of the staff had received training in challenging behaviour, or epilepsy awareness. Restraint and intervention did not feature on the training schedule even although staff told us one person was sometimes restrained to deliver personal care. Only one member of staff had received basic first aid and only the acting manager had received training in the Mental Capacity Act / Deprivation of Liberty Safeguards. Only two staff had received fire safety training and three staff dementia awareness. Eight staff had received manual handling training, however, certificates of training were not held by the service for three of these staff because their training was delivered by a previous employer. Additionally, only six staff had received training in safeguarding of vulnerable adults and four in infection control. Romney Cottage advertises as a service specialised in providing support for people with Korsakoff syndrome, substance abuse as well as mental health needs, however, no training had been delivered to support this or featured on the training schedule.

Discussion with the acting manager found regular staff supervision had lapsed, did not meet the service's policy and no schedule was in place to reinstate it. Staff supervision was a one to one meeting with the manager or senior staff. It is intended to enable managers to maintain oversight and understanding of the performance of all staff to ensure competence was maintained. This should help to ensure clear

communication and expectations between managers and staff. Supervision processes should link to disciplinary procedures where needed to address any areas of poor practice, performance or attendance.

Some staff told us they were unclear of their roles, some had not received contracts of employment or job descriptions. Some staff were not confident to support each person in the service; in these circumstances staff often acted collectively to deliver personal care. While this may have benefitted staff safety when faced with behaviours that challenged, it was impersonal, not considerate of individual needs and preferences and only necessary because staff lacked guidance, training and therefore the skills to otherwise deal with such situations.

The service could not demonstrate staff had acquired suitable skills and knowledge either during induction, through on-going training, competency assessments or regular supervision. No record was made available to us of any vocational qualifications achieved, such as diplomas.

Staff had not received appropriate training to enable them to carry out the duties they were employed to perform; and did not receive appropriate support, supervision and appraisal. This was a continued breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. We discussed with the acting manager an action point following a recent safeguarding meeting for a capacity assessment to be completed for a person at the service. This was to look at the level of involvement in their day to day life of another person at the service and to ensure they understood about choice and were able to consent to the other person's involvement at any level. Although an MCA assessment had taken place, it was an assessment for simple decisions in what was arguably a sensitive and potentially complex matter. Support had not been sought from an advocate or another person, for example, of the same gender, who the person may have felt more comfortable speaking with. Although the person had replied to questions asked, responses noted followed predictable patterns within their communication plan of repeating or agreeing with what had been said to them. It was unclear whether the person had understood what was asked of them, the implications of consent and whether, because of the reasons for the assessment, they may have responded differently to questions from a person of the same gender.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep them safe. The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. We discussed with the acting manager whether referrals had been made where people lacked capacity and were subject to continuous staff supervision. Although referrals had been made for seven people and a decision received for one; the acting manager acknowledged upon reflection there was one person who would be unable to leave the service without constant supervision. An application had not been made to the supervisory body for a DoLS authorisation; the acting manager considered that an application 'probably' should be made.

Records showed no other staff had received training in MCA or DoLS or been competency assessed in this area. Discussion with some staff found, although believing to be acting in a person's best interest to ensure personal care was delivered, physical restriction without consent took place to overcome a person's resistance to treatment.

This did not ensure people's rights were respected and they were protected from improper treatment. This was a breach of Regulation 13 (1)(5)(6)(b)(7)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records showed they had regular visits from GPs and community nurses. A visiting health care professional told us referrals were now made promptly by the service and communication had improved; the service was more proactive in ensuring people's health care was monitored and maintained. They did however comment that one person's skin was not healing as well as could be expected and questioned whether this was because of continence management and staff difficulty in delivering personal care; having the right training and therefore required skill set to do this. Additionally, they expressed concern that staff had not consulted with them at an earlier stage when a person developed a pressure area on their foot, given that they came to the service several times a day. Since this incident, some senior staff had received training about skin viability, this will help to ensure deterioration in skin condition is in future recognised, acted upon and brought to the prompt attention of health care professionals.
Other concerns voiced by a social care professional included that treatment was only given for a person's scalp condition once pointed out to staff it was needed. People's care files included charts for recording regular checks on areas of the body most vulnerable to pressure wounds and changes in people's weight, mobility, hydration and nutrition. These recently introduced systems allowed staff to pick up on any changes in people's condition and showed an improvement in the service's procedures. A sample review of the information completed did not show any significant changes in people's health or condition. Since most of the monitoring material was recently introduced, at the time of the inspection, there was not significantly meaningful data to compare.

Optician and dental appointments had been documented and people had regular check- ups to ensure that any general health problems were routinely identified. There were fact sheets about diabetes in the care files of people living with the condition. These provided detailed information about the symptoms of high and low blood sugar and when to call the doctor. This guidance supported staff to provide effective monitoring to keep people healthy. No concerns were identified around diabetes management.

A cook provided service between 8am and 1pm, five days a week. Meals outside of this time were served by care staff who also helped with meal preparation at other times. Meal portions were plentiful and some people also had 'Seconds' on request. The cook spoke with people individually in the morning to ask what they would like to choose for their lunch. This was carried out in a gentle and considerate way and the cook described meals to people to help them state their preference. There were plenty of drinks available throughout the day; with jugs of squash and water on hand as well as a constantly replenished tea and coffee making facilities. The weather was hot during our inspection and people were repeatedly encouraged to drink enough in a friendly and attentive way. The cook was aware of diabetic food requirements and made meals and cakes to cater for this as well as purchasing low sugar jams. Although one person likened meals to school dinners, everybody enjoyed them and was appreciative of the cook's efforts. Most people ate independently, but staff remained available to support if needed. There were no special requirements for pureed or softened meals; no one required thickened drinks.

We observed the staff hand over between night and day staff, the meeting was informative and provided incoming staff with an individual account of how people had been during the night, any health concerns and any as yet unmet needs. Staff found the meeting helpful, updates were given verbally and also written down. There was a communication book used to convey messages to and from staff and a diary of upcoming healthcare appointments. Staff felt communication in the service had improved.

Requires Improvement

Is the service caring?

Our findings

People told us staff worked hard, were pleasant, polite and made time for them. Most people felt their privacy and dignity was respected and thought staff were well-intentioned.

Our inspection in January 2016 found people were not well informed or involved in their care planning; some were unsure what their care plan was and either didn't know they could, or hadn't had the opportunity to discuss it. The provider, in their action plan, told us this would be addressed through discussion and review with people.

At this inspection, although aspects of care plans had been reviewed, they continued to lack information that could have been gained by discussion, such as interests, hobbies and personal preferences. Many were unsigned by the people they were written about. Additionally, people hadn't noticed any difference in staff speaking to or involving them in care planning; some people maintained this had not happened. Care plans are intended to give guidance about the care and support being provided and how people wanted to receive it. Care plans should be designed and agreed with the person through the process of care planning and review. Some people again told us they did not know what their care plan was and were not aware if it had been discussed with them, but were generally happy with the support they received. People felt happy they could discuss their care and support with staff if they felt they needed to, however, other people felt they had not had the opportunity to do this or did not know that they could.

The provider had failed to carry out, collaboratively with the relevant person, an assessment of their needs and preferences for care and support. This was a continued breach of Regulation 9 (1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff interactions were compassionate and well-intended; knowledge levels and a lack of awareness did not always enable staff to recognise poor care or respond in a meaningful way to some people's needs. For example, when dealing with challenging behaviour, in order to feel safe and confident, it was not unusual for staff to attend to the personal care needs of a particular person as a group of up to four staff at a time. The acting manager had noted in the person's support plan this could make the person 'aware of impending activity and become reluctant to comply'. Staff nevertheless continued with this approach and behaviour records recorded the person's resistance and distress.

Other aspects, such as the bed of a recently deceased person being left upturned against the wall of their previously shared bedroom, may have acted as a constant reminder to the remaining occupant of the death of their roommate. Language used in some reports such as writing that a person had been 'annoying' and 'acting out' when distressed about delivery of personal care was not respectful and did not reflect the ethos of a caring service.

Another person's support plan noted in relation to delivery of personal care and potential triggers of behaviour that challenged; 'there may be elements of pain, but (the person) is unable to communicate this'. Reference to their care plan found no pain assessment method in use and no pain relief medication

routinely offered.
This did not reflect the practice of a caring service or ensure that people were treated with dignity and respect. This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, observation found staff did interact with people in a kind and compassionate way. Staff maintained eye contact when talking to people; were cheerful and spoke with people at the same level to maximise communication and understanding of what was being said. Staff were cheerful, energised and had clearly developed rapports with people who responded to them with smiles and sometimes shared a joke or enjoyed a laugh with them. One carer sang to a person as they guided them to their chair, other staff sat outside and chatted while people enjoyed a cigarette. People generally appeared comfortable and at ease with staff.

Information was kept confidentially Care records were stored in a locked room when not in use. Staff understood the importance of privacy and confidentiality and there were policies and procedures to support this.

Inadequate

Is the service responsive?

Our findings

Our inspections completed in October 2014 and January 2016 found the service was not always responsive and identified improvement was required, particularly around people's activities and aspects of care planning intended to meet people's individual needs.

In their initial action plan the provider told us the 'weekly activity programme is being constantly monitored reviewed and revised to suit individual needs and capabilities. This will provide guidance to staff with extended walks / drives where suitable and other activities'.

In subsequent action plans and updates, dated 11, 18 and 24 March 2016 the provider told us 'the new manager has already started working on care plans based on a person centred tool' and 'person centred tools to be implemented and with more involvement from the individuals in the planning of care'. We were further advised this was to 'start on the 27 March 2016 and be fully implemented on the 1 April 2016, to be monitored and completed by 1 June 2016'.

On 4 April 2016 we were advised in an update from the provider 'person centred tools have been started for those residents who have been assessed as 'high risk' by the manager'; and on 26 April 2016 the provider told us 'person centred tools have been started and will be rolled across to all residents. Care Plans and Health Action Plans are continually being developed. This is an on-going programme involving all interested parties and stakeholders to ensure completeness and accuracy'.

The three subsequent updates made no specific mention of care planning intended to meet people's individual needs. No further updates were received after 14 June 2016. These were agreed as necessary during a face to face meeting with the provider; stopping of updates had not been discussed or agreed.

During this inspection we found the provider had not taken adequate steps to review and improve activities, care planning remained insufficiently developed to be individually meaningful. Adequate improvement had not been made. Additionally, we identified other areas of concern which meant that the service was not responsive.

People told us there had been no appreciable change in activities; they were doing the same things they 'had always done'. Our brief discussion with one person raised their animated and enthusiastic discussion about their interests; these were achievable, but previously unknown even although they had lived a Romney Cottage for a number of years. Although some people went on walks locally with staff and attended a day centre, obstacles to outings included the lack of a mini bus and access to public transport. While most staff drove, only the acting manager had business use insurance and, irrespective of this, risk assessments were not in place for travel. Care planning did not set out individual goals and interests and consequently no reviews or pathway maps had been completed to achieve them. Goal setting is an effective way to increase motivation and retain interest, it can help raise people's mood particularly when living with depression and other mental health needs.

Aspects of care planning remained not sufficiently developed or adequately detailed to be individually meaningful. As previously identified, continence support plans were not personalised specifically for the people they were intended to support. They did not indicate people's daily routines, their preferences for support or the extent to which people may wish to manage their continence themselves. Therefor there was no guidance for staff about how people wanted to be supported, such as, taking them to the toilet upon waking, prompting them to use the bathroom throughout the day. Where a person experienced epilepsy, although seizures were monitored and infrequent, there was no plan or guidance for staff about how the person needed to be supported. Where people had behaviours that challenged, staff had not been trained how to deal with this in a safe and consistent way. Where some staff were able to deliver personal care to these people on their own and without incident, this information had not been shared and factored into care planning to form individual, consistent and effective strategies to support them. This lack of information made it difficult for staff to develop behavioural management strategies. This would have helped to ensure people were consistently supported in ways that suited them the best. Clear links were not always made between some conditions and other associated care needs, for example, diabetes and foot condition. This was despite a safeguarding matter in which these concerns featured.

Assessment tools used to determine two people's personal care needs recorded they were 'independent with bathing and grooming'. The assessment tool clearly states it 'should be used as a record of what a patient does, NOT as a record of what a patient could do'. Observations of the people found they were self-neglecting; it appeared they were not 'independent with bathing and grooming'; this was noticeable by the odour of urine about both of the people.

One person showed us their lower leg; it was encrusted with dried skin. Although assessed by the service as being able to independently manage their personal care, medication and apply skin creams, the condition of their leg made it evident further assessment was required.

Individual needs and preferences had not been established. The provider had not designed care and treatment with a view to achieving people's preferences and ensuring their needs were met. This was a continued breach of Regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was available to people and visitors to the service. The process was displayed on the notice board and a copy held in people's care plans. People knew how to report a complaint and what the process was. The complaints policy set out how the staff should log a complaint together with various acknowledgement and response timeframes. People we spoke with told us they did not have any complaints and did not wish to make any. They told us they were confident if given cause to complain, it would be resolved quickly. The service was not dealing with any complaints at the time of our inspection.

Inadequate

Is the service well-led?

Our findings

Our inspection of 2 October 2014 found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the governance of the service, aspects of staff training and Deprivation of Liberty Safeguards (DoLS). The ratings for the service identified improvement was required for four key domains; overall the service had achieved a rating of requires improvement.

Our last full inspection on 25 and 26 January 2016 found none of the previous requirement actions had been fully met. Systems of audit and governance, although improved in relation to infection control, were ineffective in other areas because people's safety and appropriate treatment was not assured. Induction training was not evaluated and staff were not trained to operate some of the equipment they used. Staff did not have appropriate knowledge about the requirements of the law concerning the Mental Capacity Act and associated Deprivation of Liberty safeguards. Leadership and planning had failed to ensure that the requirement actions issued following our last inspection were fully met. Nine breaches of regulations were identified. We also met with the provider to make sure they understood their responsibilities and explained possible further action, should appropriate improvement not be made.

This inspection has identified nine breached regulations, many of which were multiple and continuing breaches of those previously notified. Leadership of the service was poor. The provider and acting manager did not show all the necessary skills and knowledge to provide a service and manage it effectively. They did not ensure that care was safe, that staff were trained effectively or that care was person centred. They did not have appropriate knowledge in relation to the requirements of safeguarding, restrictive and restraining practices or the law on the Mental Capacity Act.

The provider and acting manager had failed to ensure effective management action took place to fully meet the serious concerns and breached regulations previously notified to them. The provider had not demonstrated that they had the necessary insight to recognise and remedy the shortfalls in the care they provided. Consequently they had failed to develop suitable systems to continually evaluate and seek to improve their governance and auditing practice. Governance and auditing frameworks were ineffective and inadequate.

Leadership and planning had failed to ensure that all actions needed following our last full inspection were met. Action plans and updates submitted by the provider did reflect the findings of this inspection and had not assured breached regulations were met. The service lacked management action and a plan to ensure urgent, continuous improvement and development was adopted into working practices and driven forward.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and keep complete and accurate records of was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care providers must notify us about certain changes, events and incidents affecting their service or the

people who use it. These are referred to as statutory notifications. This includes notification of expected death. Discussion with the acting manager confirmed their failure to notify the Commission of a recent expected death of a person.

The registered person had not notified the Commission of events which they had a statutory obligation to do so. This is a breach of Regulation 16 (1)(a) of the Care Quality Commission (Registration) Regulations 2009.

Staff were proud of their work and worked hard; they readily took on delegated tasks when given opportunities, such as putting in place some medication protocols. However, they did not feel that the provider and acting manager were always approachable; some staff felt uncomfortable and not listened to when raising concerns about the difficulty experienced in the delivery of some personal care. They felt they did not have sufficient training and knowledge and questioned the lack of some equipment they felt may have helped; these concerns have been validated by this inspection.

Although a clear staffing structure was in place, some staff were unclear of their roles; particularly around cleaning of the kitchen. Some staff had not received contacts of employment or job descriptions, which may have resolved clarity of roles.

The provider recognised the service required improvement and was committed to see that this happened. To give them the best opportunity, approximately one month prior to this inspection, they had appointed a consultancy service who attended the service most week days. We met and spoke with one of the consultants and were told their team had undertaken a review of the service. They had identified concerns and prioritised work to address them; this had included a comprehensive audit and review of all medication processes. We asked the consultant for any development or action plan for the service, this has been provided.