Foley House Trust

Foley House

Inspection report

115 High Garrett
Braintree
Essex
CM7 5NU
Tel: 00 000 000
Website: www.example.com

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out a comprehensive, unannounced inspection to this service on the 6 January 2016.

The service can accommodate up to 21 people predominantly with a sensory impairment. At the time of our inspection there were 18 people using the service and the home accommodates both younger adults and older people. There was no registered manager in place and had not been for seven months since the last inspection which was undertaken on the 3 and 5 June 2015.

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 home had an acting manager and support from the nominated individual.

We received a number of concerns about this service from the Local Authority in May 2015 and brought a planned inspection forward. Which we carried out in June 2015. The registered manager and other staff had left the service without a period of notice. One of the

Summary of findings

trustees had taken over the day to day management of the service and the service was being supported and monitored by the Local Authority. Public accounts showed the service was struggling financially. At our inspection in June 2015, the service was rated as requires improvement in each area inspected and we found the service to be in breach of 5 of the regulations. These were: safe care and treatment, regulation 12, good governance, regulation 17, person centred care, regulation 9, staffing, regulation 18, need for consent, regulation 11 and meeting nutritional and hydration needs, regulation 14. We met with one of the trustees to discuss our concerns. We felt confident that given the short period of time they had overseen the service they were beginning to bring about service improvements and had provided much needed stability to the service. They were also interviewing for a new manager.

We received further concerns about this service in November 2015 and shared them with the Local Authority. The trustee in day to day control had left and removed from the board of trustees. There was an acting manager and the Nominated individual running the service. They had failed to notify us of changes to the services and a number of events affecting the well- being and safety of people using the service.

During the inspection in January we were not confident that people using the service were safe because risks to people's safety had not always been assessed and where they had there was insufficient information about how to mitigate the risk. Records poorly described risk and were not regularly evaluated. Records were not kept of the day to day care being provided. so we could not see what care and support was being given to people.

Staff had received training in what to do if they suspected a person to be at risk of harm or abuse and knew what actions they should take. Safeguarding referrals had been made appropriately.

During our inspection we were concerned there were at times insufficient numbers of staff and it was not clear how staffing levels were clearly determined by the needs of the people using the service. There was no consideration of the diversity of the client group and the physical environment which covered three floors. The nominated individual told us they had updated the tool they used to determine how many staff they needed and this was higher than previous staffing levels. However staff recruitment and retention was having an impact on this. We noted some people isolated in their rooms with no clear means of summoning assistance.

The medication practices we observed were acceptable but we have received information that people were not always receiving their medicines according to the prescriber's instructions and overall the service was not managing medication appropriately.

Staff training and induction was not of a consistently high standard and where people had received an induction we could not see how this demonstrated they had the necessary skills and competencies for their role.

Staff did not have sufficient understanding of the Mental Capacity Act 2015 and it was not clear how people were effectively supported with decisions about their care and welfare.

People were offered a varied, nutritious diet. However the monitoring of what people were eating and drinking required improvement.

People's health care needs were met in as much that people had seen the GP and other service such as chiropody. However in the absence of daily notes it was difficult to assess how changes in people's health over a period of time were identified or responded to.

People's needs were assessed before moving into the home but the assessments were not in sufficient detail and the plan of care did not take full account of risk.

Activities for people were very restricted and did not take into account people's individual needs, and wishes.

It was difficult to assess how complaints had been dealt with in the past due to an absence of records but procedures had improved.

The service was without a registered manager. The acting manager was not able to effectively manage as they did not always have clear management time but was working on the floor supporting care staff.

Records were not of a sufficiently high standard and did not show how risks to people's health, welfare and safety were monitored and as far as possible reduced.

Summary of findings

The service has been poorly managed over a period of time and sufficient progress in meeting breaches in regulation had not been fully addressed.

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

The overall rating for the service was inadequate. This means that the service

has been placed into 'Special measures' by The Care Quality Commission (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. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration. Services placed in special measures will be inspected again within six months. If insufficient improvements have not been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the Provider's registration.

Summary of findings

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 is not safe.

There was not always enough staff to deliver care safety.

Risks to people's health, safety and welfare were not adequately documented and people have suffered harm.

Medication practices required improvement as concerns have been identified to us and the service were not able to show actions taken since audits had been carried out

Staff recruitment was improving. Staff had been employed without appropriate checks. People were being employed after their suitability for employment had not been sufficiently verified.

The service was clean and staff were knowledgeable about infection control. Staffs knowledge had recently been updated.

Is the service effective?

Requires improvement

The service was not effective

Staff did not always have sufficient skills and experience all of the time to meet the needs of people using the service. However additional training was being rolled put

Staff did not have sufficient understanding of the Mental Capacity Act 2015 or its application.

Records did not tell us how people's health care needs were being adequately met or if people were eating and drinking enough for their needs to prevent unplanned weight loss.

Is the service caring?

Requires improvement

The service was not always caring

Most staff were kind and caring

People's independence was not always promoted and they were not always consulted adequately about their health care needs.

Is the service responsive?

Inadequate

The service was not responsive

There were insufficient staff to provide responsive care. Care was task focused as opposed to based on individual needs.

People did not have a programme of activity around their individual needs and people were not sufficiently stimulated.

Summary of findings

Care records were not always in sufficient detail, had not always been reviewed as needs changed and there was no contemporaneous record of the care provided.

There were adequate procedures in place to record complaints but only since November 2015 which made it difficult for us to assess this.

Is the service well-led?

Inadequate

The service was not always well led.

The service had no registered manager and had not for over 6 months. Staff did not all have clear roles and responsibilities.

Record keeping was poor and we could not see how the service were meeting people's needs.

Quality Assurance processes were poor and there were not audits for all aspects of care and practice.

Community involvement and engagement were poor and people did not have enough contact with their community.

Foley 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and took place on the 6 January 2015. The inspection was carried out by four inspectors. As part of this inspection we looked at information we had received since the last inspection including the last inspection reports and notifications which are important events that the service are required to tell us about. We spoke with the Local Authority about their concerns.

During the inspection we observed the care and support provided to people. We spoke with- twelve staff: the cook, activities co-ordinator, deputy manager, acting manager, trustee, administrators, (2), a senior carer, the cook, a domestic and two care staff.

We spoke with eight people using the service and looked at four care plans.

We looked at other records relating to the safety and maintenance of the building.

Inadequate

Is the service safe?

Our findings

The safety of people using the service was compromised by poor risk management and poor care practices. The layout of the building contributed to risk for people. For example the service had a number of stairwells which people could freely move up and down and the risk of doing so had not been assessed. Internal stairs were also present and staff told us there had been times when people had been bumped down these stairs in a wheelchair and one instance when a person had fallen out of their wheelchair when being pushed over internal stairs by a member of staff. This caused them distress.

We found areas were the general upkeep of the building made it unsafe or people living at the service. For example, the carpet in lounge near front entrance was very worn and threadbare in places and was a trip hazard.

Several people said they were cold in their rooms and there had been ongoing problems with the heating. Radiators were being replaced. On the day of the inspection the home was warm but we noted people had sash windows which were heavy and some people would not be able to open them by themselves. We noted when we tried to open some windows they were painted shut. This meant people were unable to regulate the temperature in their rooms.

We found that two people's walking frames were in need of new ferrules, one of which was worn through to the metal. This puts people at risk as the frames will not glide as they should and is therefore a falls risk. Walking frames should be maintained on a regular basis, and the service can easily access supplies of ferrules via the physiotherapy department, or falls team.

We observed one person sitting in the lounge area in a wheelchair. Their brakes were not on, and they had a walking frame in front of them. If they had attempted to stand, there was a risk that the wheelchair would have moved, and they could have fallen off. This risk was not identified within their care plan and staff were unaware of the risk this posed to this person. Staff were not clear as to who had which walking frame which could increase the risk to the person of falls if the frame was not appropriate to their stature. We observed poor moving and handling techniques. For example, we watched two staff assisting a person from their armchair in the main lounge. No guidance was given to the person who could have helped themselves to stand from the chair, if given the correct instruction. This method of handling this person posed a risk to their safety and did not encourage their independence. Staff training in manual handling did not always include observations of their practice to ensure staff were moving people safely.

Call bells were answered quickly and staff were attentive when providing support to people, however staff told us often when they were assisting people with personal care there would be no staff downstairs to assist people there. We also noted that some people had pendants to call for staff, but some people were left with no means of calling for assistance which increased the risks to them. One person was sitting in their room, still not dressed by 11.30 and they seemed confused when asked about their call bell. They told us they had to sit and wait until staff came to assist them. This person had no means of alerting staff if they needed to which posed a risk to their safety.

Risks to people's safety were not always recorded or clear steps stating how the risk should be mitigated. For example in relation to the risk of falls, access to the stairs and how often people should be monitored in terms of their safety. People did not have personal emergency evacuation plans in place which meant that people's support needs may not be met should they need to leave the building quickly.

Environmental risks were being addressed. Equipment such as hoists had recently been serviced. All fire extinguishers were checked in November 2015. There were monthly checks for emergency lighting, and monthly alarm test. Electric appliances were checked November 2015 and fire risk assessment in November 2015.The 5 year periodic electrical inspection was last carried out in 2014 according to the provider but they were unable to produce a certificate. The Fire officer visited in November 2015, and was due back in January. The provider reported they were happy with progress made. The EVAC chairs they currently have are not correct, as not suitable for use on carpet. They stated that they are waiting for them to be replaced and have started the process. We were concerned about staff's knowledge of fire procedures in the event of an emergency as staff though it was the role of the fire brigade to evacuate people when in fact their role is fire and rescue and the home should have a clear evacuation policy.

People had access to outdoor space but were unable to go out, without a member of staff because there was direct access to a busy main road directly outside. The risk of this

to individuals had not been assessed. The third floor had platform steps along the hallway, with handrails on either side. This was not suitable for wheelchair use. Yet people assessed as having poor mobility were based on the third floor. There was direct access to two stair wells on all floors and the main stair well and fire escape stairs these all posed a real risk to people's safety. Doors leading to the stairs on 2nd and 3rd floors did not have locks on them and were accessible to people. There was poor natural light in hallway on 3rd floor.

This demonstrated a breach of Regulation 12. Safe care and treatment. Care and treatment was not always provided in a safe way.

There were not always enough staff to meet people's health and social care needs. On the day of our inspection there were only initially two staff but throughout the day additional staff came on duty and were able to assist care staff. Some staff arrived early as they were informed of the inspection. This resulted in some people getting up later than they may have wished but it was difficult to assess this as people's personal preferences were not always clearly recorded.

Staff spoken with felt that most of the time there were enough staff and felt this was an improving picture and some recent staff appointments had been made. Staff told us they sometimes rushed people because there could be a lot to do and acknowledged care could not be person centred and was always task specific. One person told us "we are under pressure, and worried something might happen". Another told us that staff morale is low and staff are generally stressed in the home.

Another staff member told us staffing levels were alright but told us they had come from a home with even less staff which has been flagged up with the inspector for this service. Staff said they did not have time to spend with people in the morning but had more time to spend with people in the afternoon, one said they could spend 'up to an hour.' With people in the afternoon when staffing levels were better.

We raised concern about the lack of daily recording about people's needs with staff told us there was insufficient time to do this. They also said up until recently fluid records had not been completed either due to insufficient time. We observed that the acting manager assisted with providing care as care staff were not always available. Staff also informed us that the administration staff assisted with providing care if necessary when care staff were not available. We were not aware if the administration staff were appropriately trained to be providing care to people directly.

We observed that there was not always sufficient staff to deliver care safely. People were seated in several different lounge rooms with no access to call bells and with no staff in the room with them. We observed one person sitting in the lounge located by the front door and away from where the main activity was taking place who was unable to get out of their chair without help. They told us that they did not have a buzzer, if they wanted help they had to wait until a member of staff came back into the room.

Staffing rotas were being amended to reflect the needs of people. This was an improvement since the last inspection where shift patterns had been inflexible. New staff were expected to work a mixture of shifts and a more equitable rota was being worked out. The nominated individual showed us a dependency tool they had developed however they were still operating with the same staffing levels. The acting manager was not confident that the new tool would identify accurately the numbers of staff required. Since the last inspection there had been a change in the needs of the people suing the service. The provider had accepted new people into the service whose dependency needs were higher; therefore more staff were needed to provide safe, high quality care.

This demonstrated a breach of Regulation 18. Staffing which states, Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

People told us they felt safe and were at ease with staff. Staff we spoke with demonstrated an understanding about safeguarding and the reporting procedures. Staff had received some recent training as had management in safeguarding vulnerable and were familiar with the procedures they should follow. We had received a number of whistle blowing alerts from this service which means that staff know how to do this and would raise concerns as necessary. Staff spoken with said they had no concerns about safeguarding. The nominated individual had sent a number of safeguarding referrals in.

Inadequate

Is the service safe?

Observations showed that medication was administered appropriately and there were no unexplained gaps on Medication administration sheets, (MAR) for the current cycle. Spot checks showed that the amounts of medication recorded as being in stock on the running balance on the MAR were correct. There was an appropriate system in place for the management of controlled drugs. A quarterly medication audit had been introduced and had identified no major issues. We were told that this supported the most recent audit from the Provider's pharmacy supplier which was not yet available.

The person administering the medicines had sufficient knowledge of medicines they were administering and the correct procedures for administering these safely. We saw that they were using the correct codes on the MAR, for example when a person was in hospital. They told us that Boots were planning to provide some refresher training to staff shortly.

There was an appropriate system in place for the management of controlled drugs that involved two people being accountable.

Temperature checks for the room and fridge were recorded twice daily. There were gaps for 2nd and 3rd January. Temperatures were within an appropriate range for the fridge. Room temperatures were between 25.5 and 26 degrees.

Prescribed when necessary protocols were not in place for everyone, although work to develop these had started and two examples were available. The Senior care staff told us that all people were able to indicate if their PRN medication was required.

A previous external audit had taken place in November 2015 but we were told the report had not been made available. We could not see regular auditing of medicines which needs to improve.

The last internal audit had been completed in October 2015. We were told that this was new and would take place quarterly. It identified a few small issues: gaps on MAR, improvements required regarding the recording of medication (not clear what this meant); room temperatures not consistently recorded. It was not clear what action had been taken to address these.

Since the inspection we have been made aware of concerns about medication practices identified by the local authority. The local authority quality improvement team are providing support to the service to improve medication practices.

We spoke to an administrator in reference to the recruitment files and were assured that these were up to date. The nominated individual told us all staff files had been audited but they were still waiting on some documents such as Disclosure and Barring checks and references for some existing staff but were aware of the gaps. They had tightened up their recruitment process which up until several months ago had been poor.

Despite hazards in the environment the home was visibly clean and domestic staff were employed in sufficient numbers. They were sufficiently knowledgeable about how to prevent the spread of infection, for example through hand washing and the use of a colour coded cleaning system. They confirmed that there were always enough aprons, gloves and cleaning products.

Requires improvement

Is the service effective?

Our findings

Staff were not trained to meet people's needs; therefore staff were unable to carry out their duties fully and effectively. There was a computerised training matrix which the Nominated Individual updated during the course of the inspection. This matrix included staff who had left and people who were due to start but had not yet started in the organisation. We found that staff were not fully trained in relation to their role. Gaps included most notably, fire safety and health and safety. No one had received training in the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) and senior staff did not demonstrate an understanding about how to assess capacity or the circumstances in which a DoLS application should be made.

Additional training was being planned and was available for staff to sign up to but this was proving difficult due to insufficient staff available to meet people's needs. Staff told us they were reluctant to sign up for training as they needed to be available to support people using the service. The training now available included more specific training around people's individual needs and the nominated individual was able to support this as they had come from a training background.

We spoke with a number of staff. They told us they had some training relevant to their role but nothing as yet around people's specific needs. They said this was being rectified and there was lots of training available at the moment. Some staff had done or were going to enrol in higher vocational courses. One staff said they had been shadowed by more senior staff and their induction included orientation of the building and ongoing training. Another person had not shadowed a more senior member of staff and had only completed a basic induction/ familiarisation of the building. We looked at a staff file for someone who was recently employed/recently left and the only records they had were in relation to training undertaken with no evidence of shadowing. This has since been reviewed and the nominated individual has devised a more detailed induction form but it does not include details of shadow shifts. The nominated individual said new staff were shadowed but there was no written evidence of this but practices had been tightened up.

This demonstrated a breach of Regulation 19: Fit and proper persons employed. Staff did not always have the necessary skills, competence and experience for their role.

People's capacity was not assessed in line with the Mental Capacity Act (MCA) 2005. People's records mentioned them having or not having the ability to consent to their own care. However, there were no full assessments of people's capacity which advised what they could consent to and how people could be supported by staff to consent. In one person's care plan it stated that "[she] has been assessed as eligible and requiring a deprivation of liberty safeguard." But no DoLS applications had been completed at this time. It also stated that "[person] has very limited mental capacity and is unable to make informed decisions."

In a number of people's records. It stated that they would need support to raise a concern or with some decisions and should be supported by an advocate. No advocate had been named or identified and when we asked staff they said it would be a family member and everyone had family to support them. Advocates should be independent and not a family member.

This demonstrated a breach of Regulation 11: Consent. Staff did not have sufficient understanding of the Mental Capacity Act 2015 or how to support people who could not fully consent.

During our inspection we observed lunch time. People were supported to access the dining room from 1.00 pm and a choice of drinks was offered. Lunch was served at 1.10 pm and looked hot, appetising and was nicely presented. Lunch was relaxed and social and there were enough staff to offer support to people. We saw that people enjoyed their food and were offered drinks and snacks throughout the day. The Cook was knowledgeable about people's individual dietary requirements and gave examples of how they met their preferences and needs. They told us "No one needs extra calories." "There are no puree or liquid diets." We could not verify this information in the absence of other records about people's needs. We did however see in one person's record that they were on a soft diet and it was not clear how this information was effectively communicated.

Food was cooked and prepared on the premises. One person told us that they liked the food but that you had to eat what was cooked for you, which indicated a lack of

choice. However the nominated individual said menus had changed recently and there was now more choice. People told us that they felt that they had enough to eat. Staff told us that there was no effective system in place to ensure that people's fluids were maintained and that people received sufficient fluids.

The Cook did speak to people about what they wanted to eat, however they did not check that people enjoyed their meals and did miss opportunities for interaction. People were not offered second helpings or asked if they were still hungry, they were all offered a desert. People had their evening meal at five p/m but it was not clear what the arrangements were for supper or if snacks were readily available. Staff were unable to tell us how people's dietary needs were met at night and there were no records of this. People had their breakfast about nine a/m so potentially there was a big gap between people's evening meal and breakfast the next day.

There was no evidence that people were weighed monthly or more regularly if required; this meant that potential issues with regard to eating and drinking may not be identified. We spoke with the administrator and nominated individual who told us that everyone had just been weighed but in the preceding months only some people had been weighed. We noted for people who had been newly admitted to the service there was no weight record or assessment of their dietary needs. The administrator told us they were putting people's fluid intake on to a computer record but had only just starting doing this. Paper records did not give us a good picture of how much people were eating and drinking. There were lots of gaps and nothing recorded after people had their evening meal. Fluid intake was not evaluated to ensure it was sufficient to people's needs and it was not clear how much they expected people to drink or what to do if they did not. Because of the limited information recorded each day about how people's needs were met according to their care plan it was impossible to see how people's health care needs in relation to hydration and food intake were measured. The nominated individual told us the weekly menus had been revised and snacks were readily available for people to help themselves. However when we asked staff they told us there were drinks mid-morning and mid-afternoon and snacks provided were biscuits or cakes. Staff were not sure about a later evening drink.

This demonstrated a breach of Regulation 14: Meeting nutritional needs.

It was not clear how well people's health care needs were met because there were no daily records and care plans had not been updated for several months. We saw entries which showed people had been referred to other health care professionals such as the GP, optician, dentist, and district nurse. However gaps in record keeping gave us concern in terms of frequency. For example, a person with diabetes only had two entries that they had seen a chiropodist in 2015 and may have needed further support in this area. Care plans did not tell us if actions had been followed up. For example a record told carer's to refer to the wheelchair service in October due to increased difficulty with transfers for the person but there was no further updates. This meant that it would be very difficult for staff to understand what the difficulties were and how to respond to them appropriately. There was no guidance on how to meet people's specific health care needs. For example in relation to cognitive impairment. We asked what happened when people went to hospital given the support they might require. The acting manager told us a member of staff went with people until a family member could arrive at the hospital. We were concerned about what support this left for other people at the service. The acting manager said they would photocopy MAR sheets and sections of the care plan but there was no specific information to help hospital staff in terms of people's main needs. We saw further examples of where people's health had declined rapidly but because care plans had not been updated as needs changed and daily notes were not kept we could not see how a change in need had been responded to and if the response was sufficient to need. So for example where a person had a urinary tract infection, we could not see if staff mindful of this and encouraging adequate fluids.

This demonstrated a breach of Regulation 9 person centred care which states care and treatment of service users must be appropriate and meet people's needs.

Requires improvement

Is the service caring?

Our findings

Interactions between staff and people who used the service were caring although focused on the task in hand. There were missed opportunities for interaction during the day because staff were extremely busy. People spoken with said the care staff were nice and did not have concerns about people's practices.

We did identify some good interactions. In one of the lounge areas we observed two members of staff assisting someone to transfer from their wheelchair into an armchair. They took time to make sure that they were comfortable and cushions were in the right place. They offered them a blanket and went to get their pendant alarm. We noted one person who was comfortable and able to write responses to our questions. They told us they were very comfortable and staff were nice and kind. A visiting professional told us that staff were interested to get know people and did spend time talking with people.

During at lunch time we observed that people's interactions with staff depended on whether they required staff support with their care. During lunch we observed a member of staff sit down next to a person at a dining table. The staff member began to eat and drink in front of them without acknowledging or speaking to the rest of the people at the table. Once the member of staff had eaten without speaking to anyone they stood up and left the table. Another member of staff asked the same people if they could join them for lunch, then spoke to other members of staff while they ate. At lunch time we observed that people were able to ask for smaller portions.

We were concerned about our observations of one person just finishing their breakfast. They had a sensory impairment and were sat with three other people none of whom were deaf or could sign. The person became distressed as felt the others were being unkind. One person told us, "Some people in the home, had mental problems." The compatibility of people's needs had not been considered and people's tolerance of others was a concern. This was brought to staffs attention and they could not say how people's different needs were managed within the home. Staff did provide comfort to the person once brought to their attention.

We saw a number of examples were people's independence was not appropriately promoted and people's dignity was not always ensured by staff. For example, we observed the lunch menu being shown to one person, hand written on a piece of paper. This person was able to communicate well, and the use of this was therefore not needed and was disempowering to the person. The staff member was not aware of their abilities and did not promote independence or dignity effectively. We also observed that immediately before lunch a person was waiting to be supported with their mobility to move to the dining table. Staff acknowledged them but assisted other people. They became distressed but staff did not respond and continued to help others as this person continuously tried to get out of their chair unaided and unsafely.

Some of the terminology used by staff was not appropriate and did not promote people's dignity. They referred to people 'wandering' rather than showing an appreciation of people's individual needs and health conditions. However we also saw some examples where staff were able to communicate with people in a way that enabled them to understand. For example, some staff members used sign language to communicate with people who were deaf. Others lip read or people wrote down questions/responses for staff. A member of staff told us that that one person had sat in the office with them and contributed to writing their care plan.

Overall we found that people were not consistently involved in planning their own care. Care plans did not always have their needs or choices about how they would like to receive their care recorded. People's life history was not consistently recorded in their care plans, we did not see any 'This is me' which is a more detail summary of people's life story/history/previous employment. This helps staff understand people's needs better. In one person's care plans we saw advice for staff on what to do if they became distressed and in another care plan for a person who had dementia and could not always find their room advice for staff to place their room key on a large yellow key fob with their room number on it to help them find their room.

Inadequate

Is the service responsive?

Our findings

One person told us that they regularly go out with the staff activities person and activities included shopping, and attending a day centre. We observed someone being encouraged by staff to clear away breakfast things in the dining area. We observed that some people living in the service had a sensory impairment. All the televisions had subtitles on but some people with poor vision were seated too far away from the television to be able to read the subtitles.

There was an activities co-ordinator in post who worked for 12 hours a week (4hours a day 3 times a week). This time included time to take a person to day centre. This was insufficient to the needs of people using the service. We were told that keyworkers were to plan different activities for people using the service. We were given an example of what one person had an interest in that staff said they would support them with. The activities co-ordinator told us that they took people out weekly based on who wanted to go out. We asked about people with limited mobility and were told that they could go out where possible but this required additional support from an already stretched staff team. The service had two vehicles available to transport people, but we were unable to establish the last time either was used or how many staff were able to drive them. The activities coordinator said they could also use a taxi if needed. If people did go out, they tended to go shopping in the local town, to the park, or out for coffee. Carers told us that they decide where they take people after asking for their preference.

What we were told by staff was not always happening in practice. One person told us that they had not been out for 2 years. They told us that some people go out every week and that they would like to be able to go to a day centre or somewhere but that they do not get the opportunity "the problem is that we don't go out enough."

One person who was visually impaired and hard of hearing told us that they never go out. They used to enjoy reading, painting and drawing but due to a decline in their vision they could no longer do these activities. They told us that now "there wasn't much to do" so they just sit in the lounge and look out of the window. They used to have their chair facing a wall but one of the carers had suggested that they moved it so that they could look out of the window and they found it much better now. They told us, "Staff sometimes sit and chat but not very often."

Another person told us they were bored and had nothing to do and expressed their increasing frustration. Later they asked if they could go out to which staff responded it was icy outside. It was in fact a clear day; staff did not offer to accompany the person. This person said the only things for them to do was occasionally watch television and read the newspaper. Another person told us they did not have many visitors and there was nothing to do all day other than to watch television.

Organised activities included: bingo, arts and crafts, and board games, watching DVD's, exercise groups, gardening in the spring/summer. We were told there was a timetable to tell people what activity was happening but this was not seen on the day. Staff told us that a few people went out but not the majority. They also said there were no outside entertainers coming into the home other than a carol service at Christmas.

Through our observations when the television in the communal room was on it was not clear if the programme was the choice of people in the home and was not being watched by anyone. The television remained on as activities were taking place. The radio was on in the dining room but again It was not clear if it was people's choice.

Not everyone received the opportunity to engage in activities that met their individual needs and preferences. Bingo was offered as an activity on the day of our inspection and five people actively participated. There were eight people in the room. One person told us that they didn't really like bingo therefore they didn't tend to join in with the organised group activities. Another person told us that there were no real activities organised occasionally bingo but they weren't keen on it.

We observed that not all people were being supported to remain cognitively and physically active. Activities were not provided on a one to one basis or for those who chose to remain in their rooms. We asked how people choosing to stay in their rooms were occupied and were told, "I just give them a book." One member of staff that we spoke with told us that people could decide when they wanted to get up and when they wanted to go to bed and if they wanted to sit in the lounge or remain in their rooms. However, people

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told us that could not choose when to get up and when to go to go to bed. One person said "I go when I'm told, but this usually suits me." One staff member told us that if people's religion is Church of England they can have communion. No other religious denominations visit the home. They thought everyone was Church of England but could not be sure.

A new format for care plans had been introduced in June 2015 and the provider was close to completing these for everyone who lived at Foley House. Although risk assessments and support plans had been completed, there was no information that demonstrated that these were regularly reviewed. For example there was not a monthly record of people's weight so it would be very difficult to monitor changes. There was limited life history information in the care record viewed; however there was some good information about people's preferred routines and guidance for staff on how to support people. There was evidence that people were supported to access health care professionals. Daily records were not kept in adequate detail which meant that changes or issues may not be identified, monitored or addressed. It was impossible to know how people were on a day to day basis as records were really poor.

We looked at a number of archived records for people and for people recently admitted to the service. Their care plans were not in as much depth as the care plans which had recently been updated. They did not include enough detail about who was already known to this person in terms of professional contact details to ensure continuity of care/ support. The care plans did not really identify what the actual need was and how a disability affected the persons day to day skills or what they could do for themselves or what they needed help with. We saw a care plan for one person which gave more detail such as 'needs help with buttons,' whereas others just stated, 'general assistance required for personal care', and 'normal diet- eats most foods' which is not specific enough. We saw some specific goals which had been set but no instruction about how staff should best support the person to achieve them.

This demonstrated a breach of Regulation 9 person centred care which states care and treatment of service users must be appropriate and meet people's needs.

A new complaints book had been started. There was a note at the front stating that the old one could not be found. We saw that there had been two complaints logged since November 2015. The date that the complaint had been made, by whom and the nature of the complaint had been recorded. However, there was no record of the date that the complaint had been resolved and no name or signature of the person that had dealt with the complaint.

Several people told us how cold their rooms had been and one person said they had raised a concern but this had not been addressed and they had not been told how it was going to be rectified.

This demonstrated a breach of Regulation 16, complaints.

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Is the service well-led?

Our findings

The lack of transparency on the part of the trustees has been a cause for concern over the last year. We were first notified of concerns at the service by the Local Authority in May 2015 these concerns were not highlighted to us by the trustees or nominated individual. We were not notified that the manager had left along with three other members of staff or the financial difficulties within which the service was operating. We were not notified when the trustee who took over the day to day control of the service also left. We have not been notified of a number of incidents and events or information has been patchy.

This demonstrated a breach of Regulation 15: Notice of change which states we must be notified when the person managing the service or carries out the service changes and also with regards to financial insolvent.

The service was not consistently well managed. Some staff that we spoke with reported that they felt well supported by senior staff and that they were approachable. One staff said. "If you ask them something they always get back to you." One member of staff felt that they could ask the acting manager anything and if they could help they would.

The acting manager had significant, relevant experience and had been working at the service for about a year and a half. first on nights and since June on days and in the position of acting manager. They told us what their key responsibilities were but also said progress in achieving this had been delayed due to staffing levels. They said they should have three administrative shifts and two care shifts supported by administrative staff but were not always able to adhere to this as needed to support the staff team to provide care when the service was short of staff.

The lines of accountability at Foley House were not clear. For example it was not clear if the Senior, Deputy Manager or Support Team Manager was in charge of the shift. Similarly, it was not clear if the Deputy Manager and Support Team Manager were routinely scheduled to work on the floor or whether they just helped out when the home was short staffed. Although the service was a member of care staff short, on the day of our inspection, it was not clear how staffing was organised to address this. The Deputy Manager and Support Team Manager helped out during lunch on the day of our inspection as did a member of the domestic team. This meant that there were enough staff to support people over lunch. We were told that the office administrator would sometimes help out too, when the service was short staffed. We also noted there were three administrators and they were unclear about their roles and responsibilities and any overlap.

Records were poor and we noted that people's personal records were stored in a filing cabinet by the front door so was not held confidently. Records could not be produced over a period of time and there were significant gaps in existing records such as staff files with no evidence of induction, probation or any disciplinary hearings. Staff told us there had been big changes since May 2015 when the Care Manager left together with other administrative and care staff. Data from the computers was wiped out and there were no care plans in place for people. These documents were now in place but there was no established roles for staff in terms of who should be updating care plans and other records

The service did not have a quality assurance policy as such. The Nominated Individual advised us that the Interim QA Policy was not yet written but involved: Improving documentation such as care plans. Reviewing all audits. Instigating quarterly relative meetings (first one taken place) and dealing with Complaints

We did not see examples of any audits, with the exception of medication. There were no call bell audits, which we specifically asked about. No other audits were made available Therefore it was difficult to know how the service assessed the quality of the service it provided. Although individual pieces of work were in place to address issues facing the service, these did not be structured in a planned way that would enable progress to be measured.

There were some examples of work to assess and promote quality could be seen. For example the relative questionnaire and recent relative meeting identified positive aspects about the service and areas where improvements could be made. Minutes showed that the first relatives meeting had taken place on 16th December 2015. Concerns about staffing, activities and a request for a hairdresser had been discussed. Feedback from staff/ management had been given at the meeting about the issues facing Foley House. The Nominated Individual said arrangements for hairdressing had been made immediately, which was to ask a member of staff to fulfil this role as required. Relatives and friends had been invited to provide feedback on the service via a questionnaire with

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a request for responses by November 2015. Thus far six had been returned. Mostly positively comments were received. The areas for improvement related to social and recreational activities, the appearance of the service and its garden, the opportunities for suitable companionship within the home.

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A complaints book had recently been instigated and this included details about issues and how they were resolved. However, it was not clear if the process followed the provider's complaints policy.

This demonstrated a breach of Regulation 17: Good Governance which states there need to be systems in place to assess, monitor, and improve the quality and safety of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was not ensuring that people always received safe care and treatment. They were not fully assessing risks to individuals or risks arising from the environment.** **Regulation 12- 1, 2 (a) (b) (c) (d) (e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider was not maintaining sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.** **Regulation 18 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The provider did not ensure all staff had the necessary skills and competencies.** **Regulation 19 (b)**

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

Staff were unclear about the Mental Capacity Act 2015 so were not able to demonstrate how they supported people lawfully.

Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider was not maintaining a suitable record to show how they were assessing and evaluating people's care to ensure it was appropriate to their needs. Regulation 9 (a) (b) (c) 3 a-i.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes The provider was not keeping us informed of events affecting the management of financial solvency of the business. Regulation 15 (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance A) The provider did not have adequate systems in place to assess, monitor and improve the service. B) It did not assess, monitor and mitigate risk C) It did not maintain a contemporaneous record in respect of each service user. D) It did not maintain records securely.

This section is primarily information for the provider

Enforcement actions

Regulation 17 (a)-(b) (c) (d)

Regulated activity	Regulation
	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints We could not see how complaints were resolved and to the satisfaction of the person raising the concern. Regulation 16 (a)

The enforcement action we took:
We issued three warning notices for failing to have a registered manager and breaches of regulation 9: Person Centred care and Regulation 12 safe care and treatment.